THE REPUBLIC OF UGANDA

REFUGEE HEALTH STATUS REPORT

BASED ON UGANDA DEMOGRAPHIC AND HEALTH SURVEY 2022

SEPTEMBER 2025

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September 2025

The 2022 Uganda Demographic and Health Survey (2022 UDHS) was implemented by the Uganda Bureau of Statistics. The 2022 Refugee Health Status Report provides in-depth analysis of the UDHS datasets.

Information about the 2022 UDHS should be obtained from the Directorate of Population and Social Statistics, Uganda Bureau of Statistics, Colville Street, P.O. Box 7186, Kampala, Uganda; Telephone +256-414-706-000; E-mail: ubos@ubos.org; Internet: www.ubos.org

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PREFACE

The 2022 Uganda Demographic and Health Survey (UDHS 2022) was designed as a follow up to the1988-89, 1995, 2000-01, 2006, 2011 and 2016 Uganda DHS surveys. The data collection for the 2022 UDHS was implemented between 20th May and 23rd December 2022 by the Uganda Bureau of Statistics (UBOS) in collaboration with the Ministry of Health (MOH). Financial assistance was provided by the Government of Uganda, the United Nations population Fund (UNFPA), the United Nations Children's Fund (UNICEF), United Nations High Commissioner for Refugees (UNHCR) and World Bank.

The main objective of the UDHS 2022 was to obtain relevant data on the demographic characteristics, family planning, maternal mortality and infant and child mortality among the Ugandan population. Another objective was to collect information on health care services and activities, antenatal, delivery, and postnatal care, children's immunizations, and management of childhood diseases. In addition, the survey was designed to evaluate the nutritional status of mothers and children, to assess the level of knowledge about HIV and AIDS among men and women, determine the extent of interpersonal violence and the quality of the drinking water in households. For the first time the UDHS 2022 included two major topics: (i) Water quality testing and (ii) Refugee module.

The Uganda Bureau of Statistics would like to acknowledge the efforts of several organizations and individuals, particularly the Economic Policy and Research Center (EPRC), who contributed immensely to the compilation of this maiden UDHS thematic report on Refugees. The report provides in-depth analysis of the health status of refugees in the country.

We urge the planners, policy makers and the general public to utilise the findings from this survey to make informed decisions and guide policy development. Relatedly, the academia and researchers are encouraged to undertake further analytical work to provide an in-depth understanding of key topical areas that affect the quality of life of Ugandans.

Chris N. Mukiza (PhD)
EXECUTIVE DIRECTOR

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CHAPTER ONE: INTRODUCTION AND METHODOLOGY

Uganda hosts the largest refugee population in Africa and the 4th largest in the world. Most come from South Sudan, the Democratic Republic of the Congo, Somalia, and Burundi. Uganda has an open-door policy on refugees. They are given land to live on and for farming. They move freely, access social services such as education, start businesses and find employment like any other citizen.

The Uganda Bureau of Statistics (UBOS), in collaboration with the United Nations Population Fund (UNFPA) and The United Nations High Commissioner for Refugees (UNHCR), incorporated a refugee strata component in the 2022 UDHS to obtain information on the socio-demographic characteristics of the refugee population.

Data collection in the refugee settlements occurred from December 2022 to February 2023. This report provides information about refugees on socio-demographic indicators, health, family planning status in Uganda. Specifically, the information on fertility, marriage, sexual activity, family planning, nutrition, childhood mortality, maternal and child health, among other related key related indicators.

1.1 SURVEY OBJECTIVES

The primary objective of the 2022 Refugee UDHS was to provide estimates of basic demographic and health indicators. Specifically, the main objectives were:

1) To collect data at the national level, which allows the calculation of key demographic indicators, particularly fertility and childhood mortality rates.
2) To provide data to explore the direct and indirect factors that determine the levels and trends of fertility and child mortality.
3) To measure the levels of contraceptive knowledge and practice
4) To obtain data on key aspects of maternal and child health, including immunization coverage among children, prevalence and treatment of diarrhoea and other diseases among children under age 5, and maternity care indicators, including antenatal visits and assistance at delivery.

5) To obtain data on child feeding practices, including breastfeeding, and collect anthropometric measures to assess nutritional status in women, men, and children.
6) To collect data on the knowledge and attitudes of women and men about sexually transmitted diseases and HIV/AIDS, potential exposure to the risk of HIV infection (risk behaviours and condom use), and coverage of HIV Testing and Counselling (HTC).
7) To measure key education indicators, including school attendance ratios, level of educational attainment, and literacy levels.

The information collected is intended to provide policy makers and program managers with information for planning, designing, monitoring, and evaluating population and health-related programs and interventions effectively.

1.2 SAMPLE DESIGN

The sampling frame used for the survey is the frame of the 2014 National Population and Housing Census (NPHC). The census frame is a complete list of census Enumeration Areas (EAs) created for the 2014 NPHC. The sampling frame contains information about the EA location and the estimated number of households.

At the time the survey was conducted, the administrative areas were stratified into 2 sub-regions. The 2022 UDHS sample was designed to provide estimates of key indicators for the country, for West Nile and South Western Uganda as separately. The refugee population include the following districts: Adjuman, Arua, Isingiro, Kamwenge, Kiryadongo, Kyegegwa, Lamwo, Moyo and Yumbe.

The survey sample was stratified and selected in two stages. Samples of EAs were selected independently in each sub-region in two stages. Implicit stratification and proportional allocation were achieved at each of the lower administrative levels by sorting the sampling frame within each sampling stratum before sample selection, according to administrative units in different levels.

The allocation of the sample EAs features a power allocation with a small adjustment because a proportional allocation would not meet the minimum number of clusters per survey domain required for the survey. The sample EAs were selected independently from each stratum using probability proportional to size.

The first stage of sampling involved selecting Enumeration Areas (EAS) from the sampling frames; the non- refugee areas and the refugee settlements used separate sampling frames. Enumeration areas (EAs) delineated for the 2014 National Population and Housing Census (NPHC) were used as the sampling frame for the non- refugee areas. A sampling frame provided by UNHCR, was used as the frame for the refugee settlement domain. A total of 77 clusters were selected with probability proportional to size from the EAs covered in the refugee frame.

Thirty households were selected from each EA, and for EAs that had less than 30 households, all the households were selected for the sample. In total, a representative sample of 2,276 households was randomly selected for the survey. All women aged 15-49 who were either usual members of the selected households or visitors who slept in the households the night before the survey were eligible to be interviewed. In one-third of the sampled households, all men aged 15-54, including both usual members and visitors who stayed in the household the night before the interview, were eligible for individual interviews.

In a sub-sample of one eligible woman in two-thirds of households (those households not selected for the male survey and biomarker collection) and one eligible man in one-third of households (those households selected for the male survey) was randomly selected to be asked questions about domestic violence.

1.3 QUESTIONNAIRES

Four standard UDHS questionnaires were used for the refugee survey namely: Household Questionnaire, Woman's Questionnaire, Man's Questionnaire, and Biomarker Questionnaire. These questionnaires, based on the DHS Program's standard Demographic and Health Survey questionnaires, were adapted to reflect the population and health issues relevant to refugees.

The Household, Woman's, and Man's Questionnaires were programmed into tablet computers to facilitate Computer-Assisted Personal Interviewing (CAPI) for data collection purposes. The Household Questionnaire listed all usual members of the households and visitors to the selected households. Basic demographic information was collected on the characteristics of each person listed, including their age, sex, marital status, education, and relationship to the head of the household. The parents' survival status was determined for children under age 18. The data on age and sex of household members obtained in the Household

Questionnaire were used to identify women and men who were eligible for individual interviews and anthropometry measurement and to identify children for anthropometry measurement. The Household Questionnaire also collected information on characteristics of the household's dwelling unit, such as source of water, type of toilet facilities, materials used for the floor of the dwelling unit, and ownership of various durable goods. The Household Questionnaire further collected information on the ownership and use of bed nets, disability, and child discipline and water quality.

The Woman's Questionnaire collected information from all eligible women aged 15-49. These women were asked questions on the following topics:

1) Background characteristics: age, education, and media exposure
2) Reproduction: children ever born, birth history, and current pregnancy
3) Family planning: knowledge and use of contraception, sources of contraceptive methods, and information on family planning
4) Maternal and child health, breastfeeding, and nutrition: prenatal care, delivery, postnatal care, breastfeeding and complementary feeding practices, vaccination coverage, prevalence and treatment of diarrhoea, symptoms of acute respiratory infection (ARI), fever, knowledge of oral rehydration salts (ORS) and use of oral rehydration therapy (ORT).
5) Early childhood development
6) Marriage and sexual activity: marital status, age at first marriage, number of unions, age at first sexual intercourse, recent sexual activity, number and type of sexual partners, use of condoms, knowledge and experience of obstetric fistula, and female genital cutting

7) Fertility preferences: desire for more children, ideal number of children, gender preferences, and intention to use family planning.
8) Husband's background and woman's work: husband's age, level of education, and occupation, and woman's occupation and sources of earnings
9) HIV/AIDS and STIs: knowledge of AIDS and STIs, methods of transmission, sources of information, behaviours to avoid STIs and HIV, and stigma.
10) Knowledge, attitudes, and behaviours related to other health issues such as injections, smoking and chronic diseases.
11) Domestic violence

The Man's Questionnaire was administered to all men aged 15-54 in the sub-sample of households selected for the male survey. The Man's Questionnaire collected similar information as the Woman's Questionnaire, although it was shorter and did not contain a detailed reproductive history or questions on maternal and child health.

During the 2022 UDHS, interviewers used tablet computers to record all questionnaire responses during the interviews. The tablet computers were equipped with Bluetooth technology to enable remote electronic transfer of files, such as assignments from the team supervisor to the interviewers, individual questionnaires among survey team members, and completed questionnaires from interviewers to team supervisors. The Computer- Assisted Personal Interviewing (CAPI) data collection system employed in the survey was developed by the DHS Program with the mobile version of CSPro. The CSPro software was developed jointly by the U.S. Census Bureau, Serpro S.A., the DHS Program and UBOS.

1.4 TRAINING

The staff who participated in this survey were part of the 2022 UDHS. Their training course included instruction on interviewing techniques and field procedures, a detailed review of questionnaire content, instruction on administering the electronic questionnaires, mock interviews between participants in the classroom, and field practice interviews.

1.5 FIELDWORK

Data collection was conducted by 17 field teams, each consisting of one team leader, three female interviewers, one male interviewer, one health technician, and one driver. The health technicians were responsible for anthropometry measurements and water testing. Electronic data files were transferred from each interviewer's tablet computer to the team supervisor's tablet computer every day. The field supervisors transferred data to the central data processing office via IFSS.

1.6 DATA PROCESSING

All electronic data files for the survey were transferred via IFSS to the UBOS central office in Kampala, where they were stored on a password-protected computer. The data processing operation included registering and checking for inconsistencies, incompleteness, and outliers. Data editing and cleaning included structure and consistency checks to ensure completeness of work in the field. The central office also conducted secondary editing, which required the resolution of computer-identified inconsistencies and coding of open-ended questions. The data were processed and edited using CSPro software.

1.7 RESPONSE RATES

Table A shows the results of the household and individual interviews, as well as response rates. A total of 2,308 households were selected for the 2022 UDHS refugee sample, of which 2,300 were found to be occupied. Of the occupied households, 2,276 were successfully interviewed, yielding a response rate of 99.0%. In the interviewed households, 2,456 women aged 15–49 were identified as eligible for individual interview. Interviews were completed with 2,360 women, yielding a response rate of 96.1%. In the subsample of households selected for the men's survey, 600 men aged 15–54 were identified as eligible for individual interview, and 549 were successfully interviewed, yielding a response rate of 91.5%.

Table A: Results of the refugee household and individual interviews.
Number of households, number of interviews, and response rates, according to residence, UDHS2022

	Residence		
Result	Urban	Rural	Total
Household interviews			
Households selected	1,169	1,139	2,308
Households occupied	1,167	1,133	2,300
Households interviewed	1,149	1,127	2,276
Household response rate[1]	98.5	99.5	99.0
Interviews with women aged 15–49			
Number of eligible women	1,367	1,089	2,456
Number of eligible women interviewed	1,314	1,046	2,360
Eligible women response rate[2]	96.1	96.1	96.1
Interviews with men aged 15–54			
Number of eligible men	302	298	600
Number of eligible men interviewed	286	263	549
Eligible men response rate[2]	94.7	88.3	91.5

[2] *Respondents interviewed/eligible respondents.*
[1] *Households interviewed/households occupied.*

1.8 ABOUT THE REFUGEE HEALTH STATUS THEMATIC REPORT

The Uganda Demographic Health Survey 2022 Thematic Report on health status among the refugees, the host community and Uganda provides a comprehensive analysis of the health state of this population. This report provides a summary of a few indicators, while the detailed findings are presented in the UDHS main report. The report comprises three (3) Chapters. Chapter 1 Introduces the Report, Chapter 2 presents the household and housing characteristics. Chapter 3 presents the results and findings of population under study.

CHAPTER TWO: HOUSEHOLD AND HOUSING CHARACTERISTICS

2.1 HOUSING CHARACTERISTICS AND HOUSEHOLD POPULATION

Housing characteristics are a reflection of the socio-economic stratification within societies. Access to electricity is a fundamental aspect of modern living that affects the quality of life and health outcomes. Table 1 shows a stark contrast in electricity access among refugee households, host communities, and the national average, revealing a significant socioeconomic divide. Specifically, only 4.3% of refugee households and 15% of host community households have electricity, while access at the national level is about double that of the host community households. This gap indicates the economic hardships refugees often face and the broader systemic issues of resource inequality.

The disparity in housing quality between refugee households and the host community is a significant concern, as highlighted by the data on flooring materials in Table 1. The prevalence of earth, sand, or dung floors in nearly 90% of refugee households indicates a stark contrast to the national housing standards, where such floors are less common. Specifically, host community households (74%) are less likely than refugee households (89.7%) to have this type of floor. Furthermore, earth, sand, or dung floors are also much rarer at the national level (57.7%). About 4.5% of both refugees and host community households use dung for the flooring material, but at a much higher rate nationally at about 13%.

The spatial dynamics within households, particularly the number of sleeping rooms relative to occupants, is a critical factor in assessing living conditions and health risks. Overcrowding can significantly increase the likelihood of spreading infectious diseases, as close quarters facilitate the transmission of pathogens. **Table 1** shows that, 42%, 40%, and 42% of the surveyed refugee, host community, and national households respectively reported having one room for sleeping. At least 33.5% of refugee households use two rooms, and 25% use three or more rooms for sleeping.

The reliance on solid fuels for cooking and heating is a significant issue in Uganda, as it is in many other parts of the world where access to clean energy is limited. Solid fuels include charcoal, wood, straw, shrubs, grass, agricultural crops, and animal dung. Using solid fuel in Uganda is almost universal, with 95.4%, 93.6%, and 91.5% of refugees, host communities, and national households using solid fuel for cooking (Table 1). Among refugee and host community households, wood is the primary cooking fuel (74% vs 79%, respectively), while charcoal is the most used cooking fuel nationally (52.5%). The smoke produced from burning these materials indoors can lead to serious health problems, particularly respiratory infections, which are exacerbated in poorly ventilated spaces.

The 2022 UDHS also provides critical insights into the prevalence of tobacco smoking within homes, highlighting the public health challenge posed by both active and passive smoking. The bottom part of Table 1 reveals that refugee households have a 4.8% daily exposure rate to smoking, while host community and national households have higher rates of 8.8% and 6.9%, respectively. Interestingly, the weekly exposure rates are generally lower, with host community households being an exception where the weekly exposure rate is significantly lower than the daily rate (2.4% vs 8.8%).

2.2 HOUSEHOLD POSSESSIONS

The presence of durable consumer goods within a household serves as a tangible measure of its welfare status. These goods, often seen as basic necessities in modern society, extend beyond their primary functions to enhance the quality of life. A radio, mobile phone, or television acts as a window to the wider world, offering educational content, news, and entertainment that can inspire and inform. A refrigerator is essential for food safety, preserving nutrients and preventing spoilage, while also enabling families to save money by buying in bulk and reducing waste. Similarly, owning a means of transport, whether it's a bicycle, motorcycle, or car, can significantly broaden a family's access to employment opportunities, healthcare, education, and social activities, which might otherwise be inaccessible due to distance. These assets, therefore, are not just indicators of economic status but are instrumental in fostering social mobility and improving overall well-being.

Mobile phones are the most prevalent household effect. Table 2 shows that two-thirds of refugee households have mobile phones, however, the host community and other households have better access to mobile phones at 78% and 79%, respectively. The table also shows very low ownership of other communication devices among refugees, especially radios and television; only 17.5% have radios, and 3.3% report having televisions. About one-half of host community households have radios, and one in ten has televisions. Possession of TVs is much higher nationally at 24%. Language limitations may explain the low possession of radios and TVs among refugees. It is challenging to understand programs broadcast in a language one does not speak or understand. The distribution of ownership of communication gadgets has implications for programming—the mediums used for information sharing or refugees may differ significantly from those used to reach the host community.

Table 2 highlights a significant disparity in the ownership of transportation means between refugee households and those at the national or host community levels. The low percentage of bicycle ownership among refugee households (6.5%) compared to the national average (26.4%) and host community households (23.5%) suggests limited mobility options for refugees. This gap widens further when considering the ownership of motorcycles and cars, with only 1.8% of refugee households having access to these, in stark contrast to the 15% ownership rate among host community and national households. Such disparities in transportation access can have profound implications for the daily lives of refugees, affecting their ability to access essential services, employment opportunities, and social integration.

As part of the Self-Reliance Strategy to empower refugees to sustain their livelihoods, the GoU committed to providing land to refugees for settlement and agriculture as an enabler towards self-reliance during rural settlements. The assumption was that they would use the plots to grow crops and rear animals to improve their standard of living. Table 2 further shows that 12% of the refugee households report owning land. In comparison, 75% of host community households and 65% of national households own land.

The relatively low land ownership among refugee households is partly in line with previous research that showed refugee land ownership among relative newcomers is around 10% and roughly 40% and 50% for medium- and long-term refugee households, respectively (EPRC and UNICEF, 2018).[1] On the other hand, refugees are about as half likely to own farm animals compared to their counterparts in the host community or the rest of the country.

2.3 HOUSEHOLD COMPOSITION AND LIVING ARRANGEMENTS

Table 3 indicates that women account for the largest share of refugee household heads. According to the table, women are in charge of 58.4% of refugee households, while Uganda has a rate of 33%. Displacements are associated with the loss of male family members because of death, injury, or separation, and women often survive such traumatic events and end up as family heads; global estimates for 2022 showed that women and girls accounted for 51% of the total refugee population (UNCHR, 2022).[2] Refugee households are, on average, larger than their host community counterparts—the average household size is 5.2 among refugee households compared to 4.5 among host community and national households.

The statistics on household composition reveal significant differences between host communities, refugee households, and national averages. Single-person households appear to be more prevalent in host communities (15.2%) compared to refugee households (11.8%). More than half of the host community and national households have four or fewer household members. On the other hand, 58% of refugee households have five or more members.

The 2022 UDHS also highlighted the critical situation of foster children and orphans. Foster children are children under the age 18 living in households with neither their mother nor their father present.

[1] EPRC and UNICEF (2018) Child Poverty and Deprivation in Refugee-Hosting Areas Evidence from Uganda

[2] UNHCR (2022) Global Trends: Forced Displacement in 2022.

Orphans are children with one or both parents dead. The absence of a parent puts foster children and orphans at risk of neglect or exploitation, which is a cause for concern. **Table 3** highlights the complex dynamics within refugee and host community households regarding the care of vulnerable children. Foster care and orphanhood are significant issues, with a notable proportion of refugee households taking in foster children (17%) and an even higher percentage caring for orphans (28%). Given that conflict is a major displacement on the African continent, refugee households have a disproportionate share of orphan children.

The table also shows that single orphans (20.9%) are more commonly found in refugee households compared to double orphans (7.1%), reflecting the broader impact of displacement and loss within these communities. In comparison, only 2% of host community households have double orphans, and 12% have single orphans. As such, refugee children face a double vulnerability arising from displacement and heightened risk of parental loss.

The data presented in Table 4 offers a comprehensive look at the living arrangements of children within refugees and host communities, highlighting significant disparities. For children under 18 in the host community, half have the fortune of living with both parents, while the rest are divided between living with only one parent or neither. Specifically, 20 percent live with their mothers but not their father (whether alive or dead); 7.6% live with their fathers but not with mother (whether alive or dead); and 22.5% live with neither of their natural parents.

In stark contrast, only a35 percent of refugee children experience the stability of a two-parent household, with the likelihood diminishing as they grow older. In refugee children aged 10-14, the trend is particularly pronounced, with only 30% of them living with both parents, compared to 43% in the host community. Interestingly, the child's sex does not significantly affect these statistics, but location and wealth do. On the other hand, the wealth status of the household does not seem to influence this aspect of family life. These figures shed light on the complex dynamics of family structures in differing socio-economic environments and underscore the challenges faced by refugee families.

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Table 1: Household characteristics

Percent distribution of households and de jure population by housing characteristics, percentage using solid fuel for cooking, and percent distribution by frequency of smoking in the home, according to residence, Uganda DHS 2022

Housing characteristic	Refugees	Host Community	National		
			Urban	Rural	Total
Electricity					
Yes	4.3	14.7	57.9	15.2	28.9
No	95.7	85.3	42.1	84.8	71.1
Flooring material					
Earth/sand	85.2	69.6	23.3	55.1	44.9
Dung	4.5	4.4	5.3	16.4	12.8
Ceramic tiles	0.1	0.8	7.3	0.9	2.9
Cement	9.8	24.1	59.8	25.8	36.7
Carpet	0.2	0.3	2.6	0.5	1.2
Others	0.2	0.8	1.7	1.3	1.5
Rooms used for sleeping					
One	41.7	39.7	51.9	38.3	42.2
Two	33.5	30.1	25.2	31.0	29.1
Three or more	24.7	30.2	22.9	30.7	28.2
Place for cooking					
In the house	15.0	5.5	14.3	6.6	9.1
In a separate building	49.6	64.7	47.9	69.1	62.3
Outdoors	33.9	25.1	33.4	22.4	25.9
No food cooked in household	1.4	4.6	4.2	1.8	2.5
Other		0.1	0.2	0.1	0.1
Cooking fuel					
Electricity	-	0.1	0.7	0.1	0.2
Solar	0.1	0.1	0.0	0.1	0.1
LPG/cooking gas	-	0.1	0.9	0.1	0.4
Kerosene/paraffin	-	0.1	0.4	0.0	0.2
Charcoal	18.6	17.3	52.5	11.2	24.4
Wood	76.8	76.3	39.9	79.8	67.1
Straw/shrubs/grass	2.2	1.4	1.0	6.8	4.9
Other	0.9	0.1	0.4	0.1	0.1
No food cooked in household	1.4	4.6	4.2	1.8	2.6
Percentage using solid fuel for cooking[1]	**99.9**	**99.6**	**90.4**	**84.6**	**86.4**
Frequency of smoking in the home					
Daily	4.8	8.8	5.0	7.8	6.9
Weekly	1.9	2.4	4.4	3.7	3.9
Monthly	1.7	3.1	3.7	4.2	4.1
Less often than once a month	4.7	5.1	4.5	5.5	5.2
Never	86.9	80.6	82.5	78.8	80.0
Total	100	100	100	100	100
Number of households	**2,276**	**2,163**	**6,323**	**13,43**	**19,75**

LPG = Liquefied petroleum gas

[1] Includes coal/lignite, charcoal, wood, straw/shrubs/grass, agricultural crops, and animal dung

Table 2: Household possessions

Percentage of households possessing various household effects, means of transportation, agricultural land and livestock/farm animals, according to residence, Uganda DHS 2022

Possession	Refugees	Host Community	National		
			Residence		Total
			Urban	Rural	
Household effects					
Radio	17.5	50.2	62.6	49.6	53.7
Television	3.3	10.8	48.1	12.7	24.0
Mobile phone	65.6	77.6	89.2	74.6	79.3
Non-mobile	0.7	0.4	3.2	0.9	1.7
Computer	0.3	1.2	6.4	1.1	2.8
Refrigerator	0.1	0.8	11.7	1.7	4.9
Means of transport					
Bicycle	6.5	23.5	19.5	29.7	26.4
Animal drawn cart	0.2	0.1	0.7	0.8	0.8
Motorcycle/scooter	1.7	13.5	13.9	11.2	12.1
Car/truck	0.1	1.5	6.0	1.4	2.9
Boat with a motor	0.3	0.3	0.3	0.4	0.4
Ownership of agricultural land	12	75.4	43.3	75.9	65.5
Ownership of farm animals[1]	32.1	65.1	42.1	68.9	60.3
Number of households	2,276	2,163	6,323	13,435	19,758

[1] Cows, bulls, other cattle, horses, donkeys, mules, goats, sheep, chickens, or other poultry

Table 3: Household composition

Percent distribution of households by sex of head of household and by household size; mean size of households; and percentage of households with orphans and foster children under age 18, according to residence, Uganda DHS 2022

Characteristic	Refugees	Host Community	National (All Uganda)		
			Residence		Total
			Urban	Rural	
Household headship					
Male	41.6	69.0	65.2	67.7	66.9
Female	58.4	31.0	34.8	32.3	33.1
Number of usual					
1	11.8	15.2	16.4	11.6	13.1
2	8.6	9.3	13.7	9.9	11.1
3	10.6	13.0	16.7	13.5	14.5
4	13.2	14.3	16.0	15.3	15.5
5	14.6	13.9	12.2	13.4	13.0
6	12.5	11.2	9.4	11.8	11.1
7	9.5	9.5	6.7	9.3	8.4
8	6.7	5.6	3.4	6.4	5.4
9+	12.6	8.0	5.6	8.9	7.8
Total	100	100	100	100	100
Mean size of households	**5.2**	**4.5**	**4.0**	**4.7**	**4.5**
	Percentage of households with orphans and foster children under age 18				
Double orphans	7.1	1.6	1.4	1.3	1.3
Single orphans[1]	20.9	11.6	9.0	10.4	9.9
Foster children[2]	17.0	24.5	21.2	26.5	24.8
Orphans and/or foster children	37.0	31.7	27.6	33.3	31.5
Number of households	**2,276**	**2,163**	**6,323**	**13,435**	**19,758**

Note: Table is based on de jure household members, i.e., usual residents.

[1] Includes children with one dead parent and an unknown survival status of the other parent

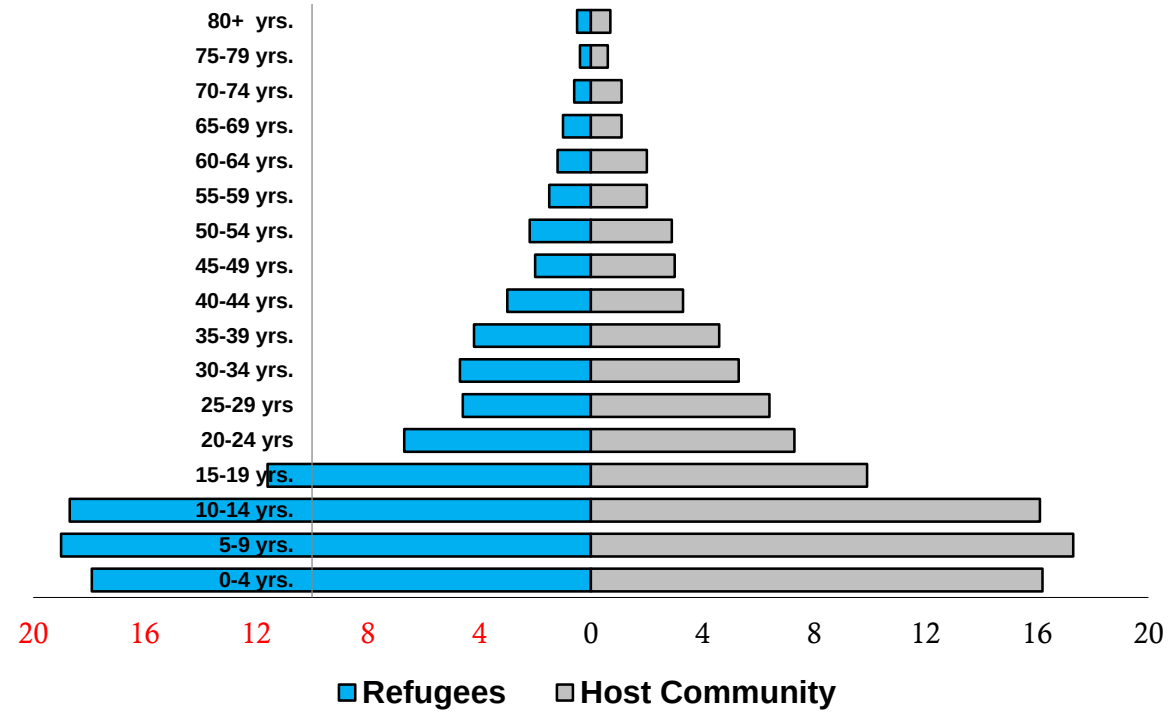
[2] Foster children are those under age 18 living in households with neither their mother nor their father present, and the mother and/or the father are alive.

CHAPTER THREE: POPULATION CHARACTERISTICS

3.1 POPULATION PYRAMID

The demographic distribution of age and sex within a population is a fundamental metric for understanding social structures and dynamics. In **Table 5**, the 2022 UDHS reveals distinct patterns between the refugee and host communities. The prevalence of more males in the younger age groups among refugees, and a higher proportion of females in the 25-39 years' age bracket, suggests differing gender ratios at various life stages. This could be indicative of migration trends, birth rates, or even survival rates. The host community's smaller gender discrepancy in the 10-19 years' age group might reflect a more stable demographic pattern. Also worth noting is the fact that adolescents account for a disproportionate share of refugees, 33.4% of males and 27.7% of females are aged 10-19 years. The population pyramids in **Figure 1** further illustrate these differences, with a pronounced base suggesting high fertility rates, especially among refugees where over half (55.6%) of the population is under 15 years old compared to 49% for the host community.

Figure 1: Population Pyramid (%)



3.2 BIRTH REGISTRATION

The birth registration process plays a critical role in safeguarding the rights of children and is recognized as a fundamental human right. It serves as the first official recognition of a child's existence and is essential for ensuring access to basic services such as healthcare, immunization, and education. In Uganda, the concerted efforts of various organizations, including UNICEF, the Ministry of Justice and Constitutional Affairs, Plan International, and the Uganda Bureau of Statistics (UBOS), supported the legal and social acknowledgment of a child but also facilitated the protection of children's rights and their well-being, contributing to the nation's commitment to international human rights standards.

The data presented in **Table 6** is an interesting illustration of the disparities in birth registration among children of different demographics and socio-economic backgrounds. It highlights that refugee children have a higher likelihood of being registered than those from host community households, with approximately 46.8% of refugee children registered compared to 22.6% of children in host communities. Notably, wealth appears to play a significant role in birth registration, with the highest wealth quintile showing more than double the registration rate compared to that of the lowest quintile in host communities (26.5% vs 10.8%). This suggests that economic factors may be a significant barrier to birth registration, which is a critical step in ensuring the recognition of a child's identity and rights. The results underscore the need for targeted interventions in the host community to address these disparities and improve birth registration rates, particularly among the poorest and those in rural areas.

3.3 EDUCATION

3.3.1 EDUCATION ATTAINMENT

Education indeed plays a crucial role in shaping an individual's potential and quality of life. Studies consistently show that education attainment affects public health and social outcomes such as reproductive behavior, fertility, infant and child morbidity and mortality, and attitudes and awareness related to family health, use of family planning, and sanitation. The 2022 UDHS collected information on educational attainment of all persons aged 3 and older in the selected households.

The educational landscape for refugees in Uganda presents a challenging picture, with a significant portion of the population having limited access to formal education. **Table 7** indicates a disparity between females and males, with a higher percentage of females having no formal education. Specifically, at least 36.1% of females and 23.3% of males age 6 and older have never had any formal education. Fifty-three percent of females and 57 percent of males have attained some primary education only, and about 4% of females and 5% of males have completed primary education, but not continued.

A slightly higher percentage of both females (6.1%) and males (11.3%) have attended but did not complete secondary education. Only 1.2% of females and 3.3% of male refugees have completed secondary or higher education. The above may reflect broader socio-economic factors that may influence educational attainment among refugee populations. The trends in educational attainment by successive age groups indicate a significant challenge within the refugee population, despite the implementation of the free Universal Primary Education (UPE) program. Table 6 shows that over half of the refugee children aged 6-9 are not attending school, with girls (57%) being slightly more affected than boys (55%). The higher percentage of 6-9-year-olds who never attended school is partly because of late enrolment.

The proportion of females and males with no education increases with increasing age. For example, 18.4% of women aged 20-24 have never attended school compared with 69.1% of women aged 55-59. The educational attainment across different age groups may reflect the historical, social, and economic context of a society. For instance, older generations may have had less access to education due to various factors, such as economic conditions, cultural norms, or political instability. The statistics also highlight a significant generational gap in educational opportunities, particularly for women, which can have lasting impacts on communities and development.

A comparison of **Table 7** and **Table 7A** reveals significant educational disparities between host community households and their refugee counterparts. A considerable segment of the host community, specifically 22.2% of females and 15.2% of males aged 6 and above, lacks any form of formal education.

This contrasts with the refugee population, where the rate of those with at least some primary education is roughly equivalent, at about 57%. Notably, in the host community, there is a higher percentage of individuals who have completed primary education but have not pursued further studies, with 8% for females and 10% for males. Additionally, the host community exhibits a marginally greater percentage of both females (9.2%) and males (13.4%) who have partially completed secondary education. However, only a small fraction, 1.9% of females and 4.7% of males, have attained secondary education or higher. Although education attainment is better among the host community,

The last columns of the two tables show the years of completed schooling for the population aged six years and above. Table 6 shows that the average number of years for refugees is 2.8 for females and 3.8 for males. For the host community, Table 7 shows that the mean school years are 3.8 and 4.7 for females and males, respectively. These low indicators of education attainment are in part influenced by the late entry into school mentioned above.

A comparison of the average number of years of education completed by gender, Table 7 shows that among refugees, the gender gaps in educational achievement emerge at the age group of 20-24 years and increase as people get older. Female refugees face many barriers to education, such as cultural norms, limited access to secondary schools in displacement contexts, and high opportunity costs of schooling in terms of income loss and unpaid care work (UNHCR, 2018).3

3.3.2 SCHOOL ATTENDANCE

As earlier noted, education is a major socio-economic factor influencing a person's behaviour and attitude. The education system in Uganda is designed to offer a comprehensive and sequential learning experience.

[3] UNHCR (2018) Her Turn: It is time to make refugees girl's education a priority.

The seven years of primary education lay the foundation in various subjects, which is then built upon during the six years of secondary education. The official age ranges for these levels are 6-12 years for primary education, 13-18 years for secondary education, and age 19-24 for university/tertiary education. Basic education in Uganda is free and compulsory, intending to provide educational attainment for all at both primary and secondary education levels.

Understanding the net attendance ratios (NARs) and gross attendance ratios (GARs) is crucial for assessing educational access and participation. The NAR provides insight into the proportion of children within the official age range who are actually attending school, reflecting the effectiveness of a country's education system in enrolling students of the appropriate age. We consider persons to be currently attending school if they have attended formal academic school at any point during the school year.

Table 8 highlights a significant disparity in educational attendance between refugee children and those from the host community. While primary school attendance is relatively high among refugee children, with equal participation of 64% for both genders, it still lags behind the host community rates of 72% for males and 73% for females. The gap widens at the secondary level, where only 6% of refugee children attend, compared to 9.2% of children from the host community. These figures underscore the challenges faced by refugee children in accessing education.

Table 8 also highlights a significant correlation between economic status and educational attainment among refugee and host community households. It indicates that as household wealth increases, so does the Net Attendance Ratio (NAR) at both primary and secondary education levels. For example, at the primary education level, among refugees, the NAR increases from 56.5% in the lowest wealth quintile to 71.5% in the highest wealth quintile. Similarly, at the secondary level, the NAR rises from 3.1% in the lowest wealth quintile to 10.5% in the highest wealth quintile, among children from refugee households.

This trend is consistent across different gender groups and suggests that economic interventions could potentially enhance educational outcomes for underprivileged groups, thereby promoting greater equity in access to education.

The Gender Parity Index (GPI) is a crucial statistical measure that highlights the comparative attendance rates of female and male students in education. It serves as a barometer for gender equality in educational access. A GPI score of 1 denotes perfect parity, meaning that females and males are attending school at equal rates. Scores below 1 suggest a disparity favoring male attendance, while scores above 1 indicate a disparity favoring female attendance.

Table 8 shows that, at the primary school level, there is near parity across the board. However, the situation changes at the secondary level, particularly among refugees and the poorest welfare groups, where the GPI drops significantly, indicating a lower proportion of female attendance compared to males. Conversely, within the host community, the GPI exceeds 1 at the secondary level, suggesting a higher attendance rate for females. These figures are indicative of the varying challenges and progress in achieving gender equality in education within different communities and economic strata.

3.4 DISABILITY

The government of Uganda has taken significant steps to address the challenges faced by persons with disabilities (PWDs). The National Disability Policy aims to promote inclusion and resilience of PWDs by suggesting actionable interventions. This policy is part of a broader commitment to protect the rights of PWDs, as evidenced by Uganda's ratification of the United Nations Convention on the Rights of Persons with Disabilities and the enactment of anti-discrimination laws. The Expanding Social Protection Programme (ESP) is another critical initiative that seeks to establish a national social protection system, providing direct income support to the most impoverished and vulnerable citizens, including PWDs.

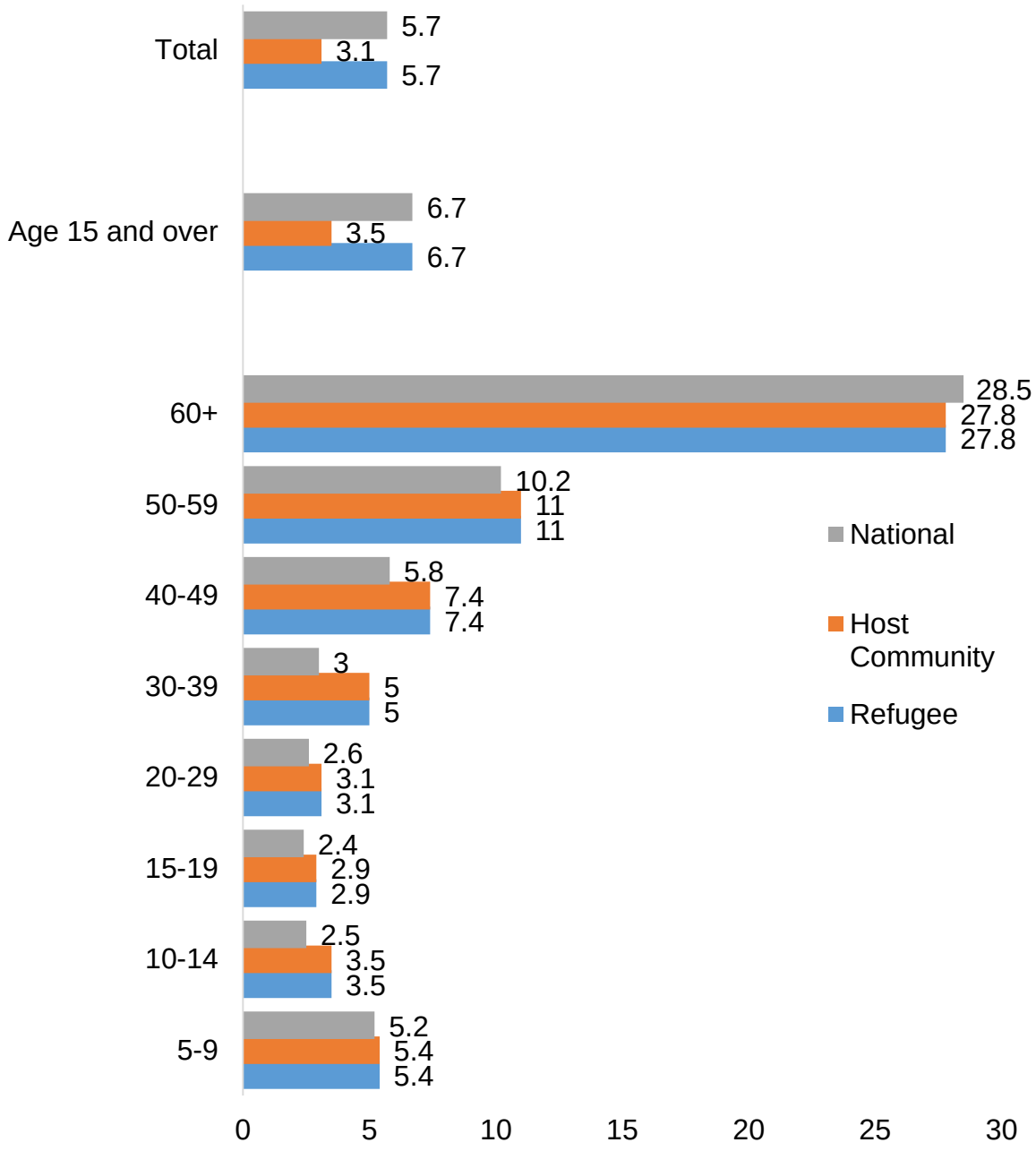
These efforts reflect a growing recognition of the importance of social protection and the need for comprehensive strategies to ensure that all citizens, regardless of ability, have the opportunity to participate fully in society and lead dignified lives.

The 2022 UDHS collected information on whether each household member aged 5 and older had difficulties with seeing, hearing, communicating, walking or climbing stairs, remembering or concentrating, or performing self-care.

Figure 2 highlights the prevalence of disability within a refugee population compared to the host community, indicating a significant portion of refugees aged 15 and above face substantial difficulties due to disability. At least 6.7% of refugees aged 15 and over have a lot of difficulty or cannot functional at all because of disability. This rate appears to mirror the national average, suggesting that disability is a common challenge across different demographics.

The prevalence of disability increases with age, from 2.5% among children aged 15-19 years to 28.5 percent among those aged 60 and above. Among persons aged 5-39, the prevalence of disability is approximately 3 to 5 percent, which increases after age 40. As individuals age, the prevalence increases significantly, starting at 7 percent among persons aged 40-49, then rising to 11% among those aged 50-59, and finally reaching 28% at age 60+ years. The increase in disability prevalence with age is a trend that aligns with global observations, where older age groups typically show higher rates of disability.

Figure 2: Disability, Having alot of difficulty or caanot do at all in at least one domain (%)



Overall, **Table 9** shows that visual impairments are the most reported disability type providing critical insights for healthcare providers and policymakers to tailor interventions and support systems that address the specific needs of these communities, ensuring inclusive and accessible services for all individuals, regardless of age or refugee status.

3.5 WATER SANITATION AND HYGIENE

3.5.1 DRINKING WATER SOURCE

Uganda's commitment to enhancing access to improved drinking water is a significant aspect of its National Development Plan III, aligning with the Sustainable Development Goals, particularly SDG 6 which aims to ensure the availability and sustainable management of water and sanitation for all.

The nation aims to reduce reliance on unimproved water sources, which are linked to the prevalence of waterborne diseases and increased healthcare demands. Access to improved drinking water is a critical factor in ensuring the health and well-being of households.

The indicators presented in **Table 10** are essential for monitoring this access, highlighting the importance of various improved water sources, such as piped water, public taps, boreholes, protected wells, springs, and rainwater collection. Lack of easy access to an improved water source may limit the quantity of suitable drinking water that is available to a household and increase the risk of illness. The disparity in access between refugee households, the host community, and the national average in Uganda is noteworthy. With refugee households having an 85% access rate compared to 77% for the host community and 82% nationally. The better access to public taps, which account for 41% of their water sources, compared to 8% for the host community and the national average, explains this slight advantage for refugees.

Public taps or standpipes are easier to provide in geographically concentrated areas, such as refugee camps or settlements. On the other hand, boreholes are the most common source of drinking water for the host community households, with 46% of them using this source. However, previous research shows that displaced populations are more prone to water-related diseases, especially diarrhoeal disease (UBoS, 2005b). One explanation is that the principal source of water supply—boreholes may not be safe for drinking because of the overcrowding issues in the camps and settlements.

Access to clean water remains a challenge in many parts of Uganda. The journey to fetch water can indeed introduce contaminants, turning even a clean source into a potential health hazard. Moreover, the responsibility of water collection often falls on women and girls, affecting their education and livelihood opportunities. Table 10 shows that in 2022, only 6.5% of refugee households have piped water in their dwellings (either piped into dwelling/yard/plot or piped to neighbour), compared to 10.4% of the host community and 15.2% of the national population. In contrast, public standpipes are the principal source of water for refugees. Approximately 4 out of every 10 refugees have access to public standpipes. Regarding the use of unimproved water sources, refugee households are less likely to use them than the host community and the national average—15%, 22%, and 18%, respectively. Within unimproved sources, refugees are more likely to use surface water (8%), whereas the host community is more likely to use unprotected wells (11.4%).

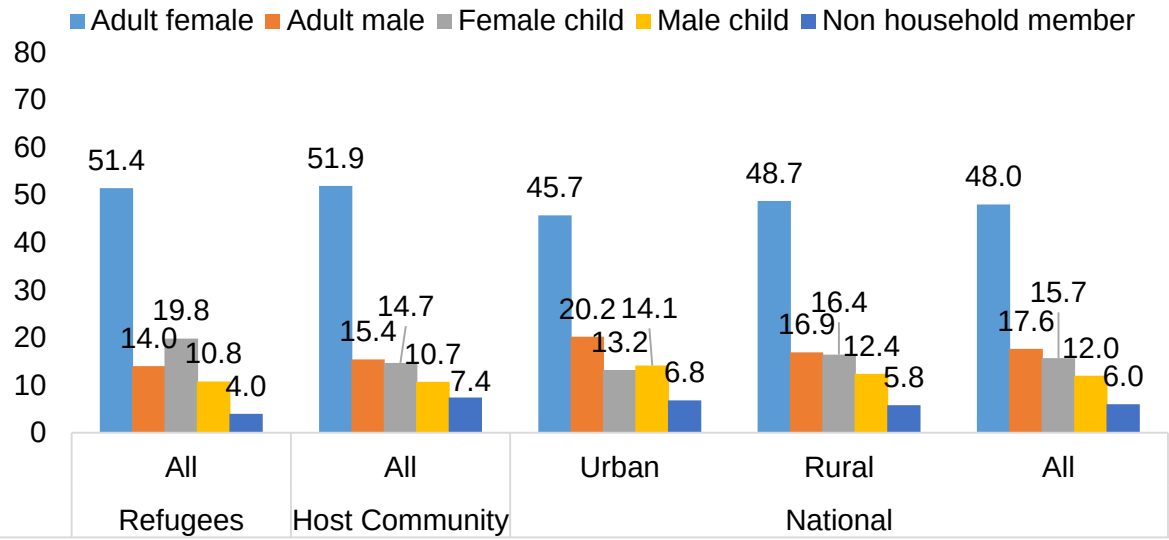
As earlier noted, access to clean drinking water is a critical component of public health. The statistics reported in Table 10 highlight a disparity in water access and treatment between refugee households, the host community, and the national average. While a majority of refugee households (62%) can fetch water within 30 minutes, the rate is lower compared to the host community (50%) and the national average (54.3%). Moreover, the fact that a significant portion of these households spend over 30 minutes to access water amplifies the concern, which can have implications for their daily lives and well-being. Specifically, at least one out of every five refugee households (22%) taking 30 minutes or longer to access drinking water, compared to 32% for the host community and 26% nationally.

The 2022 UDHS asked all households whether they treat their water to ensure that it is safe for drinking. Regarding water treatment, refugee households have a much lower rate of using appropriate water treatment methods than the national average. In particular, Table 10 shows that only 17.7% of refugee households reported boiling their drinking water, which is lower compared to 24.2% of host community households and the national average of 42%. The low usage of appropriate water treatment methods among refugee households, as compared to the national average, further exacerbates the risk of waterborne diseases.

3.5.2 PERSON COLLECTING DRINKING WATER

The results in Figure 3 illustrate the distribution of the burden of water collection among household members by age and gender. The results, regardless of geographical location, confirm the known norm that fetching water is women's and girls' work. Adult women bear the weight of the burden heavily. A gender gap exists in the overall water collection burden, with females of all ages contributing more than their male counterparts. Even among refugees, the burden of water collection falls disproportionately on females. The same rate is about 46% for both host community households and the rest of the country. The chart also shows that female children are much more responsible for water collection than male children in both refugees and the host community, that is, 19.8% among refugees and 14.7% in the host community. This disproportionate share of water collection can distract female children from education opportunities. Therefore, bringing water sources closer to the communities will benefit females, especially adolescent girls.

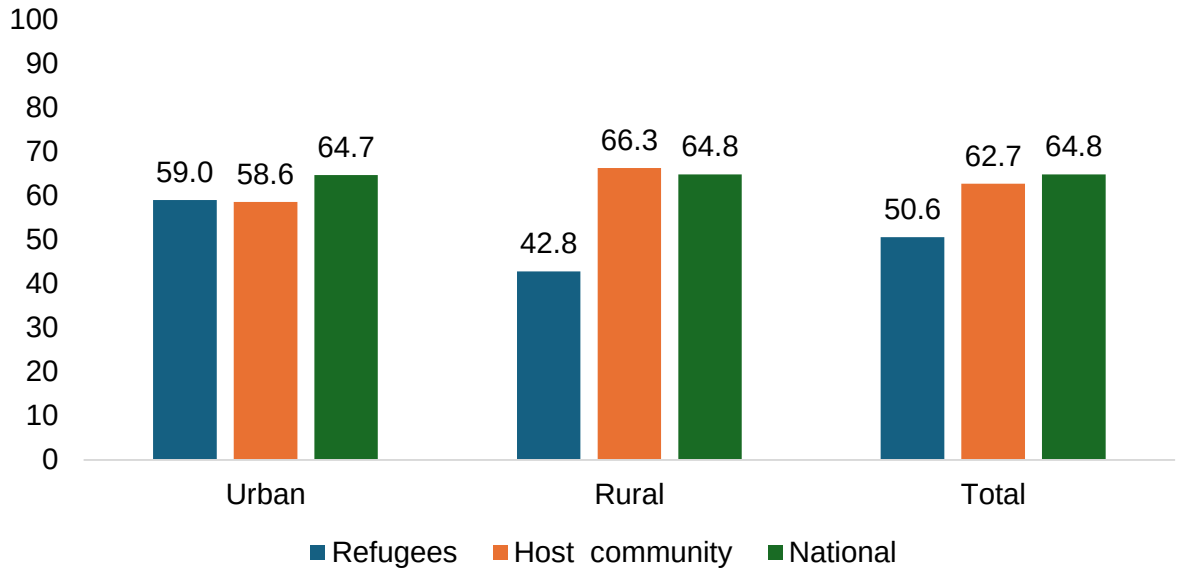
Figure 3: Persons who usually collect drinking water used in the household



3.5.3 AVAILABILITY OF HOUSEHOLD DRINKING WATER

Figure 4 shows the availability of water in the last two weeks. Among refugee households using improved drinking water sources, 51% had water available with no disruption for at least one day, compared to 63% for the host community and 65% nationally. However, wide variations between localities remain.

Figure 4: availability of water in last two weeks: Available with no interruption of atleast one day



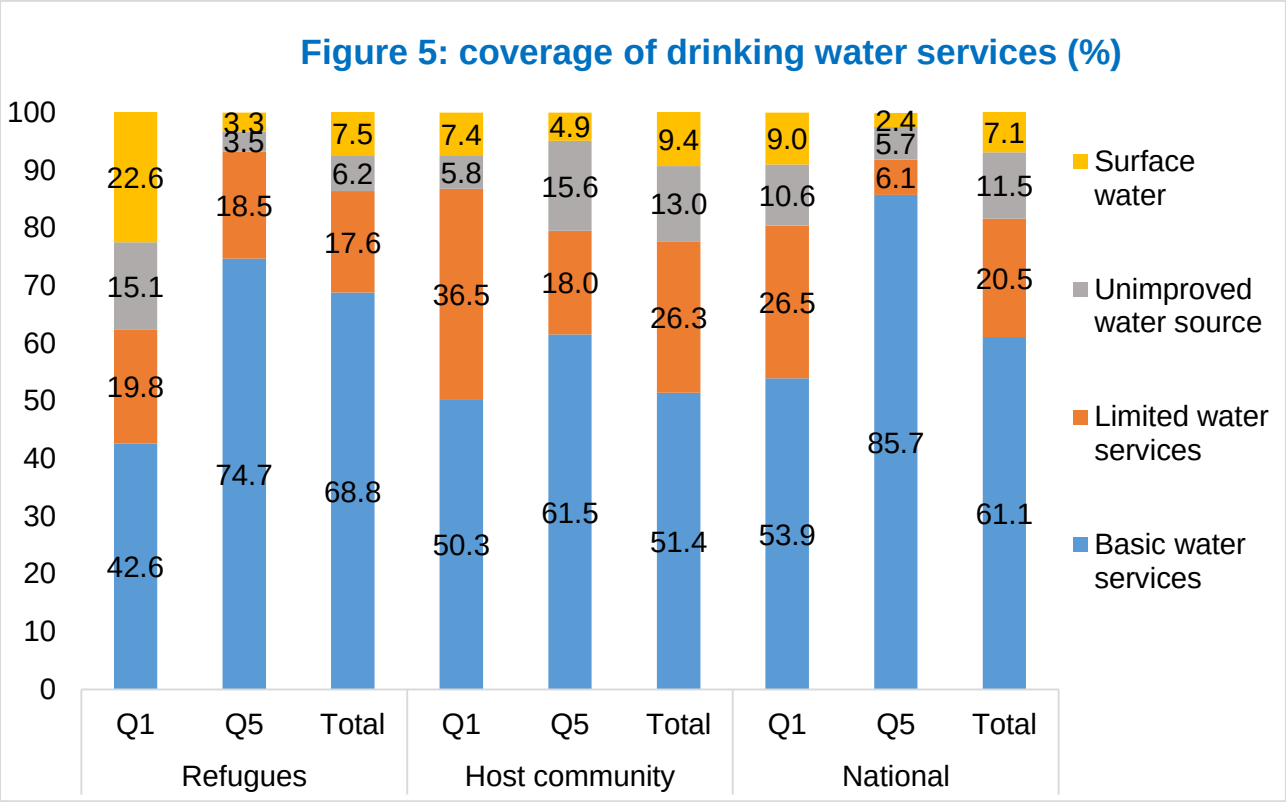
3.5.4 DRINKING WATER SERVICE LADDER

Introducing the drinking water ladder by the Joint Monitoring Programme (JMP) in 2018 marked a significant step in the monitoring of Sustainable Development Goal 6, which aims to ensure availability and sustainable management of water and sanitation for all. By categorizing water access into four levels namely; basic, limited, unimproved, and surface water, the ladder provides a clearer framework for understanding and addressing the varying degrees of water service quality across different settings and environments.[4]

Figure 5 shows the drinking water services ladder. The data presented highlights the disparities in water access among refugees, host communities, and national households, with refugees having relatively better access to basic water services. Specifically, refugee households have much higher access to basic water services—at 69% compared to 51.4% for the host community and 61% nationally.

[4]The definitions are as follows: (i) Basic—considered as drinking water from an improved source, provided collection time is not more than 30 minutes for a roundtrip including queuing. (ii) Limited—classified as drinking water from an improved source for which collection time exceeds 30 minutes for a roundtrip including queuing. (iii) Unimproved consider drinking water from an unprotected dug well or unprotected spring. (iv) Surface water-classified as drinking water directly from a river, dam, lake, pond, stream, canal or irrigation canal.

At least one out of every four members of the host community has limited access to drinking water compared to about one out of every five for refugees or nationally. However, reliance on unimproved sources like rivers and lakes remains a significant risk factor for all (6.2% among refugees, 13% for host community and 11.5% nationally), underscoring the need for continued efforts to improve water infrastructure and ensure the health and well-being of these populations.



Furthermore, there are persistent inequalities in access to basic water services, both among refugees and within national populations. Figure 5 shows a stark contrast of at least 30 percentage points between the wealthiest and poorest quintiles underscores the socioeconomic factors influencing water service availability.

3.6 SANITATION

The presence of improved sanitation facilities, which effectively separate human waste from human contact, plays a crucial role in preventing the transmission of many diseases. Such facilities, as defined by WHO and UNICEF (2010), include flush toilets connected to a sewer system, ventilated improved pit latrines, and composting toilets.

These systems not only reduce the prevalence of waterborne illnesses but also contribute to a healthier environment by safely managing waste disposal. Ensuring individual household access to these facilities minimizes the risk of contamination and disease spread, underscoring the significance of personal hygiene in the broader context of public health infrastructure.

The data presented in **Table 12** highlight the disparities in access to improved sanitation facilities between refugee households, host communities, and the national average. It is evident that while a significant percentage of refugee households (29%) have access to non-shared improved toilet facilities, this figure is slightly lower than that of the host community (35%) and the national average (31%). Additionally, the sharing of improved facilities is more common among refugee households (15.5%) compared to the host community (19.5%) and the national figure (24.3%).

The data also reveals that a substantial portion of refugee households rely on non-improved toilet facilities, which is higher than the host community and national percentages, indicating a need for targeted interventions to improve sanitation access for refugees. Approximately three out of every ten households (29%) in refugee settlements were using improved toilet facilities, and there is minimal variation compared to both the host community and the national average (Figure 6).

Figure 6: Acess to improved sanitation (%)

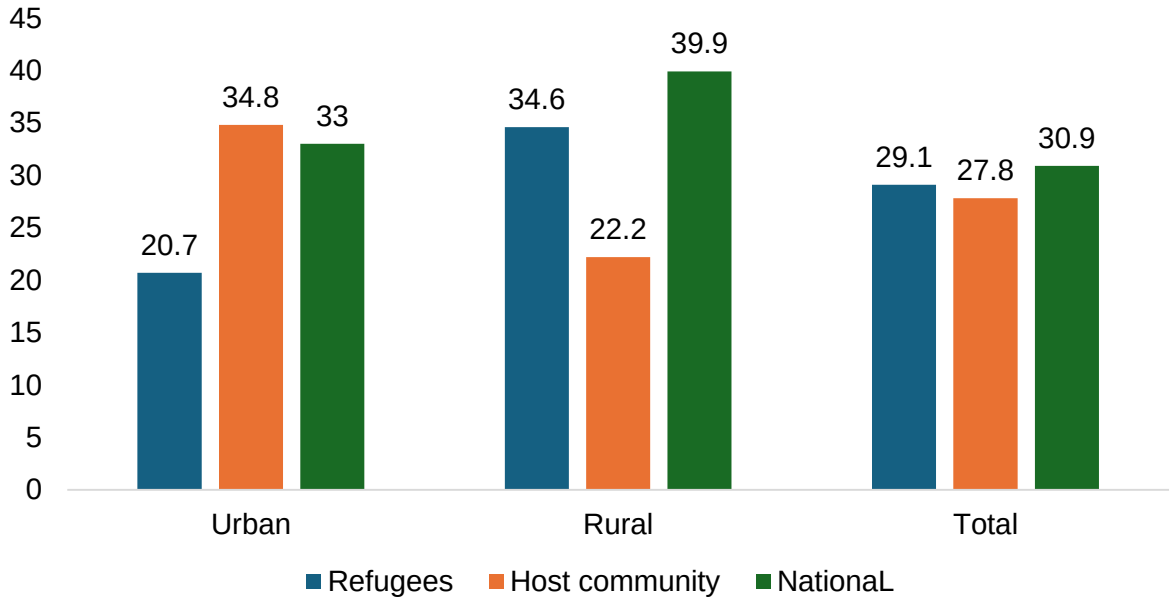
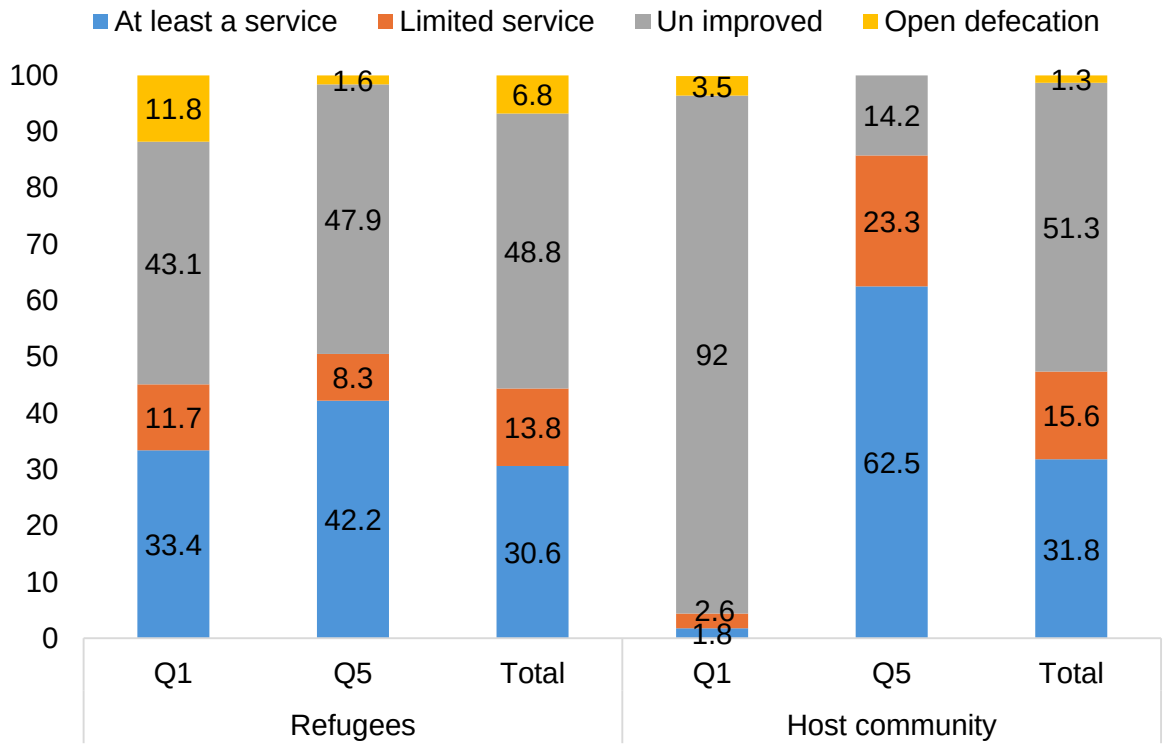


Table 12 indicates that pit latrines without slabs are the most common sanitation facilities used by both refugees (46.7%) and the host community, with a slightly higher percentage among the host community (49.9%). This type of facility, while common, poses significant health risks because of the potential for contamination of groundwater and the spread of diseases. Conversely, the practice of open defecation in rural areas, though marginally higher nationally (7.9%), remains a concern due to its direct impact on environmental sanitation and public health.

The JMP 2018 report provides a framework for assessing sanitation services, categorizing them into four levels: basic, limited, unimproved, and open defecation. Figure 7 shows significant disparities in sanitation quality, with half of the population in refugee or host communities relying on unimproved sanitation facilities. There is a pronounced disparity among different wealth quintiles. Specifically, at least nine out of every ten members of the host community in the poorest quintile use an unimproved sanitation source compared to 14.2% for the richest quintile.

Figure 7: coverage of sanitation services (%)



3.7 HAND WASHING

The practice of hand washing with soap and water is indeed a cornerstone of public health, significantly reducing the spread of pathogens that can lead to illness. This simple yet effective act is particularly crucial in preventing diseases in children, who are highly susceptible to infections like diarrhea. By promoting regular hand washing, communities can protect their most vulnerable members and improve overall health outcomes. The 2022 UDHS survey included a question about whether respondents had a specific location for handwashing after using the toilet.

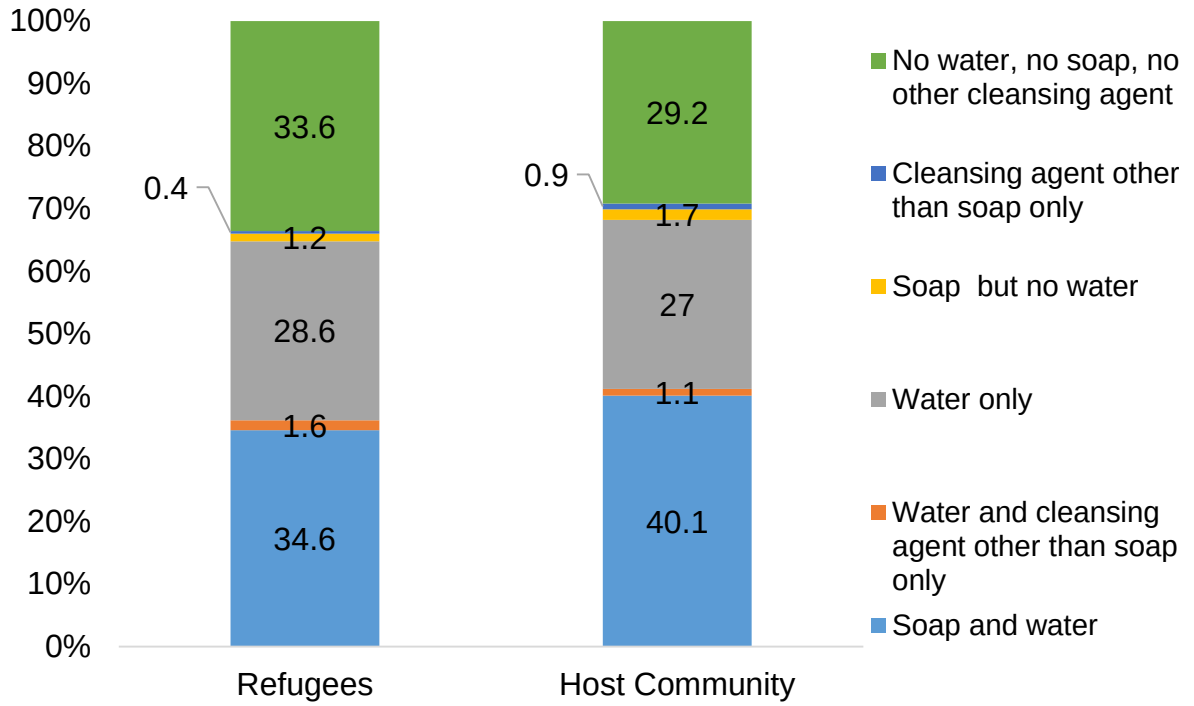
Table 14 indicates a disparity in the availability of these facilities among refugee households, host community households, and households nationally in Uganda. While over half of the national households have a place for handwashing, the percentage is lower in refugee (35%) and host community (45.3%) households. Moreover, it is important to note that only about one-third to just over 40% of these households possess both water and soap, which are essential for effective handwashing, highlighting an area for potential improvement in public health infrastructure.

Table 14 illustrates the functionality of the observed handwashing facilities. It shows that 35% of refugees have a functional handwashing facility with soap and water or another cleaning agent, while the corresponding rates are 40% for the host community and 43% nationally. Another 29% of refugee households have water only, similar to 27% of the host community.

However, about one in three households with an observed hand washing facility have neither water, soap, nor any other cleansing agent. Previous research from refugee settlements in West Nile shows that refugees who have arrived recently or stayed for less than three years are less likely to have functional handwashing facilities (Namara et al., 2020).[5]

[5] Namara, F.., H. Mendoza,**G.** Tumukunde et al. (2020) "Access to Functional Handwashing Facilities and Associated Factors among South Sudanese Refugees in Rhino Camp Settlement, Northwestern Uganda *Journal of Environmental and Public Health* Vol 2020.

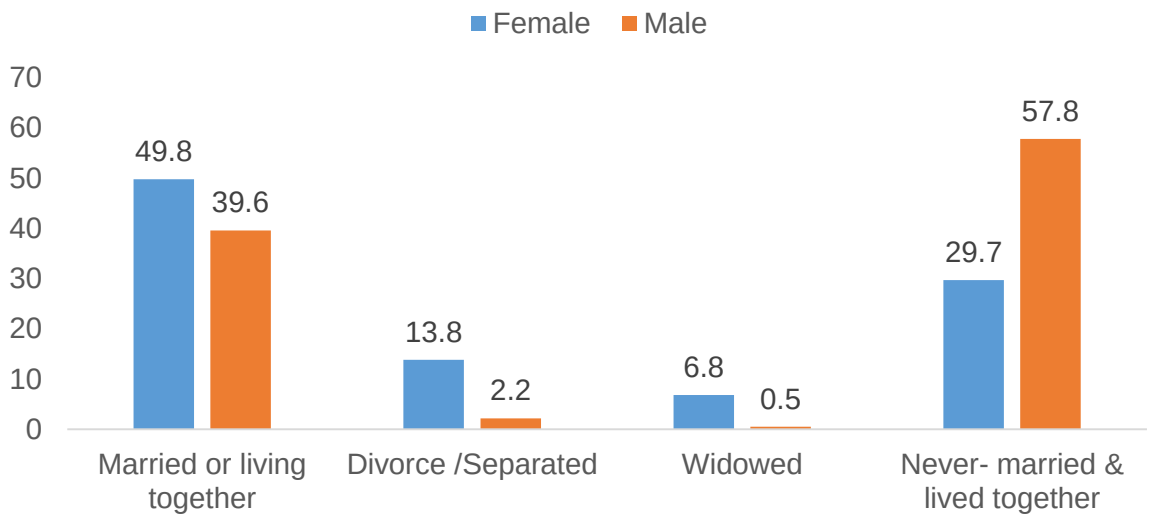
Figure 8: Among households in which a place for hand washing was observed, percentage with;



3.8 MARITAL STATUS AND SEXUAL ACTIVITY

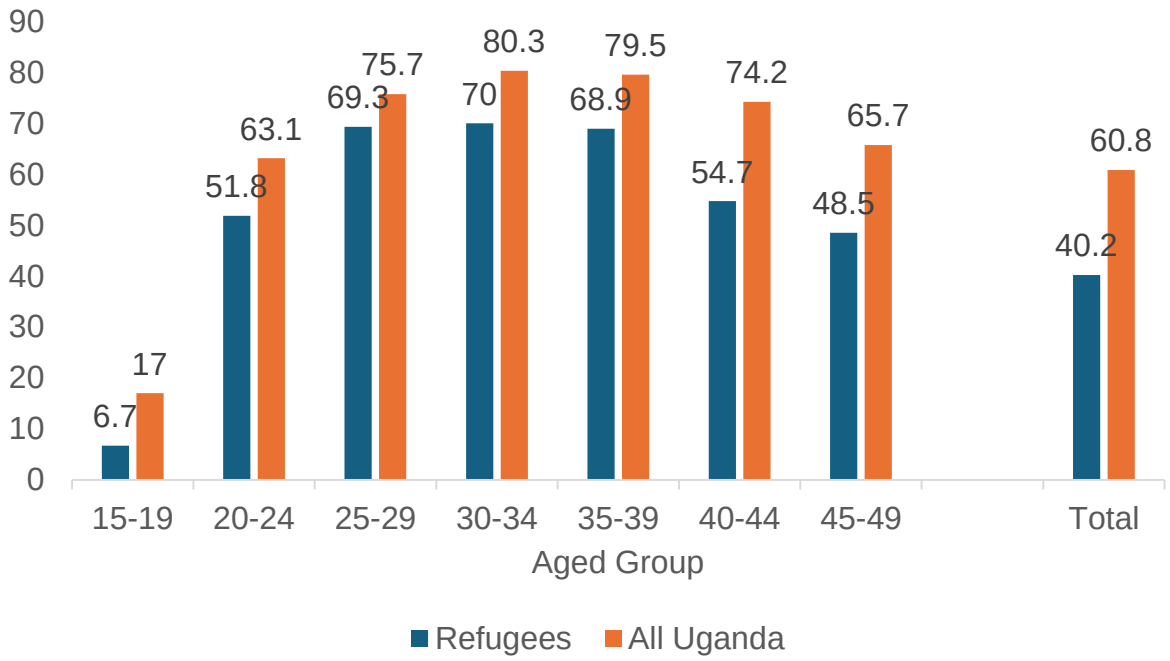
Marriage signals the onset of exposure to the risk of pregnancy for most women, and thus, it is a critical fertility indicator. In the refugee settlements, 50% of women aged 15-49 were married or living together with a partner as though they were married. (Figure 9). The UDHS 7 report showed that median age at first marriage was 19.7 years among women aged 25-49.

Figure 9: Marital Status of Refugees Aged 15-49 Years



A major determinant of maternal health is the marital status of women. Figure 10 compares the distribution of marital status by age category between refugees and the entire Ugandan population. It is indicated that refugee women are less likely to marry young compared to the general population. Specifically, marital rates among adolescent refugees are less than half of the general population (6.7% vs 17%). Furthermore, for all age categories, refugee women are less likely than the general population to be married, especially for refugees above 40 years. Overall, four out of every ten refugee women aged 15-49 years are married, compared to six out of every ten women for the general population.

Figure 10: Women 15-49 years: Percentage of Respondents Currently in Union



The overall marital rate for male refugees is similar to those of female refugees. Specifically, four out of every ten refugee men are currently married. However, as expected, male adolescents and youths aged 20-24 years have a lower likelihood of being married compared to their female counterparts. Figure 11 On the other hand shows that , male refugees aged 20-24 years are about half as likely to be married as the general population (17.5% vs 30.6%). Furthermore, unlike the case for women, refugee men are more likely to be married than men in the general population, except for the 20-24 years' age category.

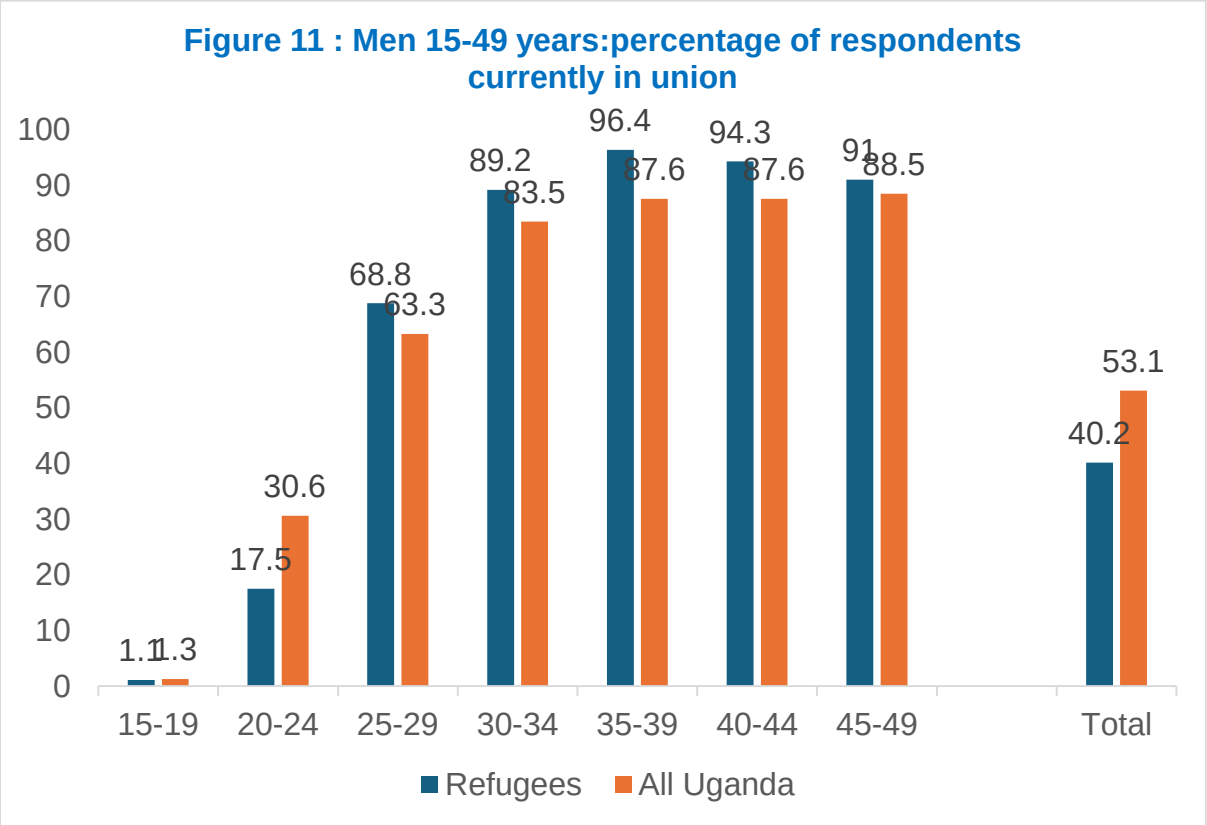
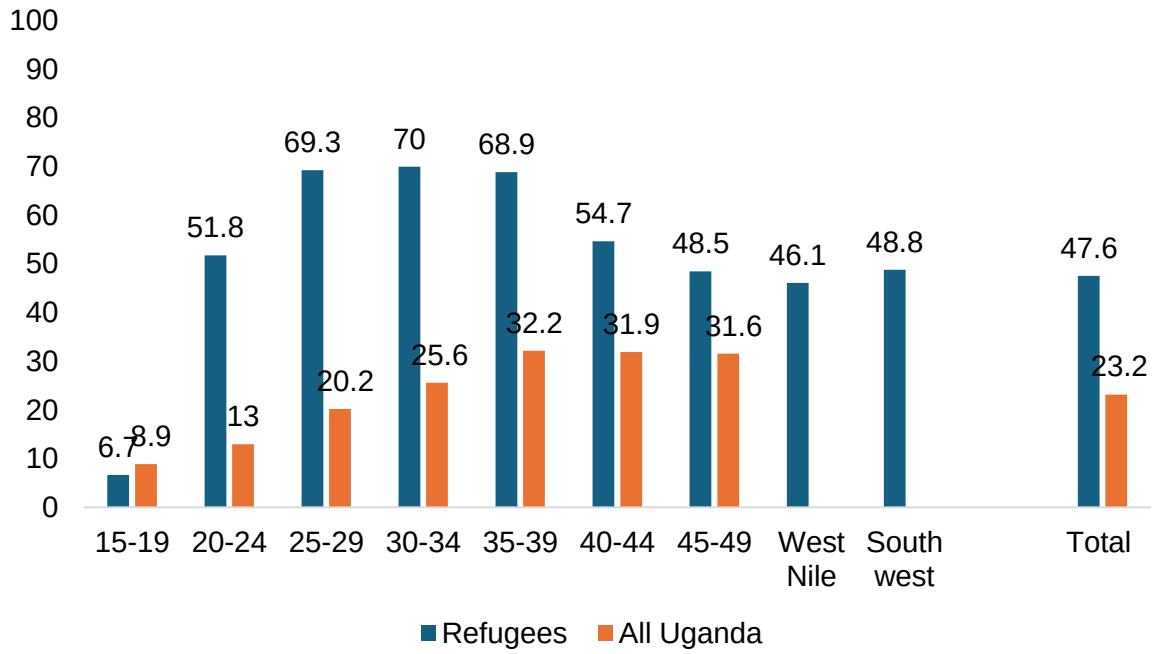


Table 15 shows the percentage of women married by specific exact ages, according to their current age. It is worth noting that only 0.8% of refugees aged 15-19 were married by age 15, compared to 2.6% of all Ugandans. The table shows that early marriages are more likely to occur among Ugandans than among refugees.

Despite the lower marriage rates among refugee women compared to the general population, they are more likely to be in polygamous unions. Figure 12 presents data on the distribution of currently married women aged 15-49 with one or more co-wives among refugees and the general Ugandan population. The cultural practices of their countries of origin contribute to the significant presence of polygamous relationships among refugee populations.

A significant proportion of refugees in Uganda, for instance, originate from South Sudan, where polygamy is widely practiced and socially accepted. Data from the 2010 Multiple Indicator Cluster Survey (MICS) in South Sudan revealed a high incidence of polygynous marriages among South Sudanese women; at least 41% of women between the ages of 15 and 49 are in polygynous unions (Ministry of Health et al., 2010).[6]

Figure 12: Percentage distribution of currently married women 15-49 with one or more co-wives.



3.9 TEENAGE PREGNANCY AND MOTHERHOOD

Teenage pregnancy and motherhood have remained a major health and social concern in Uganda because of their association with higher morbidity and mortality for both the mother and child. Besides the physiological risks, there is a negative effect on the socioeconomic status of the mother, and hence the child, because the current school policy is to have pregnant girls terminate their education.

[6] Ministry of Health and National Bureau of Statistics, 2010. South Sudan Household Survey 2010, Final Report. Juba, South Sudan.

Table 16 illustrates that among refugee teenagers, 13% have started childbearing: 11.5% have had a live birth, while 1.5% are pregnant with their first child. This incidence of teenage pregnancy is approximately twice that of the national average, where 25% of teenagers have begun childbearing. The marked disparity between refugee teenagers and the national populace is largely because of early marriages. Teenage pregnancy is significantly influenced by a woman's level of education.

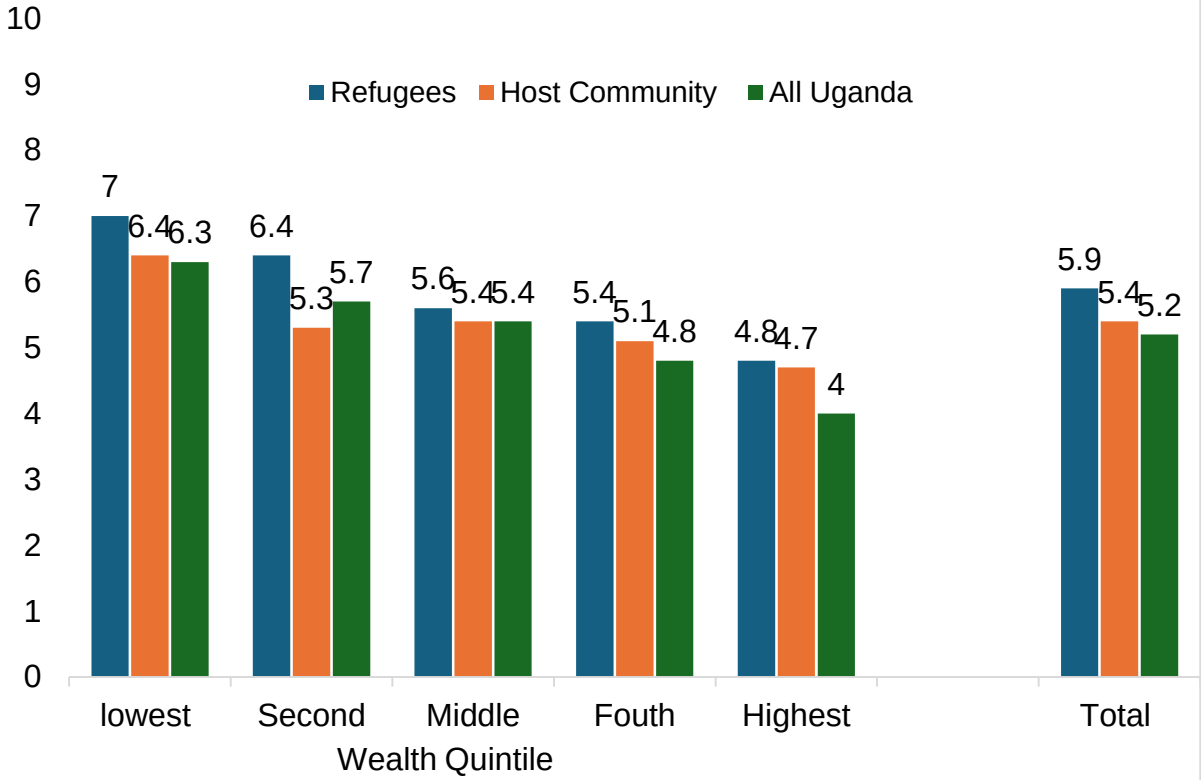
Table 16 further shows that refugee girls who have attained secondary education exhibit a 12% initiation rate into reproductive activities, whereas this figure escalates to 25% among those devoid of any educational background. On a broader national scale, the initiation of childbearing stands at 17.4% for girls with secondary education, in contrast to 27% for those lacking education.

The disparity in childbearing among teenagers across different economic strata is notable. Data indicates that within the poorest households, 21% of refugee teenagers have started families, a stark contrast to the 8% observed in the wealthiest households. Nationally, the trend continues with 33.3% of teenagers from the lowest wealth quintile embarking on parenthood, compared to 15.3% from the highest quintile. This suggests that economic factors play a significant role in early childbearing decisions.

3.10 FERTILITY

Measures of current fertility include Age-Specific Fertility Rates (ASFRs), the Total Fertility Rate (TFR), the General Fertility Rate (GFR), and the Crude Birth Rate (CBR). Figure 13 presents these rates for the three years preceding the survey. The Total Fertility Rate (TFR) in the refugee settlements was 5.9 children per woman, compared to 5.4 for the host community and 5.2 nationally. Among refugees, the TFR is highest in South West Uganda at 6.4 compared to 5.1 in West Nile. Childbearing peaks during age group 25-29 and drops sharply after age 39.

Figure 13: TFR for the 3 years preceding the survey.



3.10.1 FERTILITY PLANNING STATUS

The analysis of fertility planning levels within a society sheds light on couples' ability to manage their reproductive choices. To gauge unwanted fertility levels, the UDHS inquired women about their desires regarding pregnancies over the past five years, including current pregnancies for expectant mothers at interview time. It is necessary to exercise caution when interpreting these findings, since this method depends on accurate recollection of past desires. An initially unwanted conception may evolve into a valued child, potentially leading to post-ad hoc justification of responses, which could skew the actual rate of unwanted births.

Table 17 illustrates the birth planning trends among refugees and host communities over the five years preceding the survey. Notably, among the refugee population, 69.5% of births were planned, 30.3% were mistimed, and less than 1% were unwanted. In contrast, the host community exhibited a 5% rate of unwanted births, with a national average slightly higher at 6%.

A trend emerges among refugees where the proportion of planned births diminishes, and the proportion of unwanted births escalates with subsequent birth orders. Specifically, the proportion of planned births was 71% for first-order births, whereas this figure drops to 69% for fourth and higher-order births. Conversely, only 2% of first-order births in the host community were unwanted, which increases to 9% for fourth and higher-order births. The incidence of mistimed births remains relatively stable across different birth orders.

3.10.2 FERTILITY PREFERENCES

The 2022 UDHS gathered information on reproductive preferences. It delves into the aspirations of currently married individuals regarding childbearing, probing the timing of those desiring more children. The questions for pregnant women are tailored to uncover their wishes for future offspring post-pregnancy. Sterilized women, presumed to not want additional children, are exempt from these queries. This data is pivotal for tailoring family planning resources to meet the populace's needs effectively.

Table 18 illustrates reproductive intentions among refugee women aged 15-49. Notably, 13.8% expressed a desire to conceive within the next two years, while approximately 34% plan for childbirth in a longer timeframe of over two years. Conversely, 38% of these women have decided against further offspring, and a marginal figure of less than 1% have undergone sterilization procedures. Additionally, there is a 2% segment of currently married refugee women who remain uncertain regarding future pregnancies. When juxtaposed with national statistics, there is a noticeable difference; a slightly smaller proportion of women (32.2%) opt out of further childbearing, and the sterilization rate stands at about 3%.

Fertility preferences closely relate to the number of living children a woman has. It has been observed that an increase in the number of living children leads to an escalation in the inclination to limit childbearing. Conversely, the proportion of refugee women without living children who express a desire to conceive soon stands at 39%, which is significantly lower than the 71.5% observed among their national counterparts. Additionally, at least 7.3% of refugee women with six or more children express the desire to have another child soon, a figure that more than doubles the rate among national women at 3.6%.

3.10.3 BIRTH INTERVALS

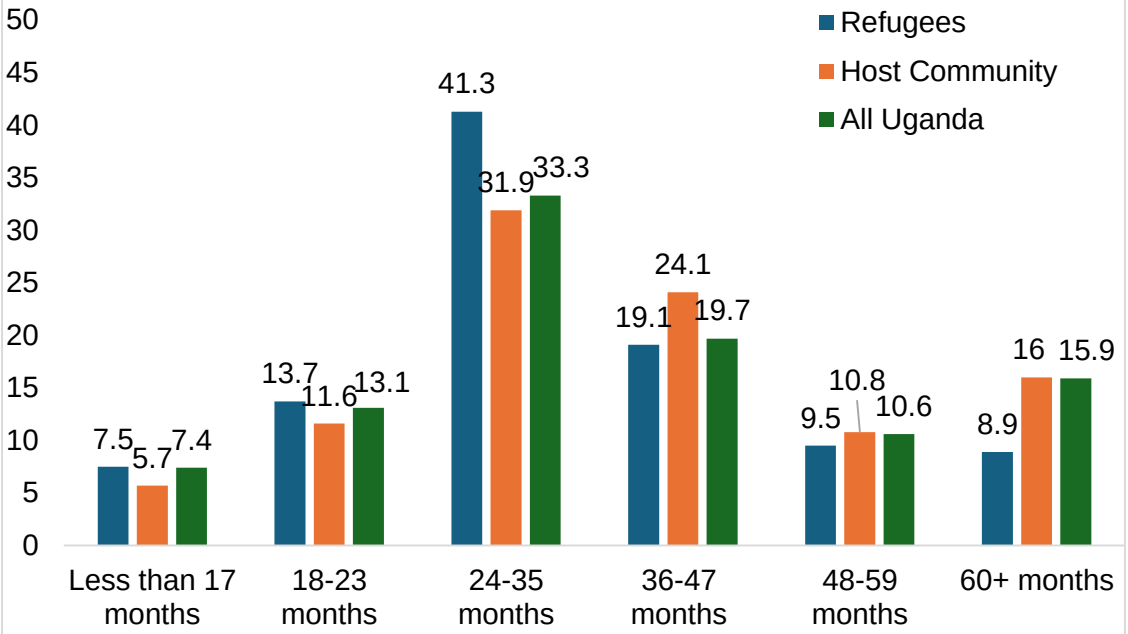
Birth interval, defined as the duration between two consecutive live births, plays a crucial role in the health outcomes for both mother and child. To significantly diminish the risks of morbidity and mortality, experts widely recommend maintaining a minimum gap of two years between any two births. This recommendation is supported by substantial research showing that shorter birth intervals are strongly correlated with adverse health effects in children, particularly during infancy. Studies by Marston (2006) and Rutstein (2005) have highlighted these concerns. Conversely, longer birth intervals are beneficial, enhancing the health and well-being of both mothers and offspring. They provide essential recovery time for the mother, both physically and emotionally, before embarking on another pregnancy. This recovery period is vital considering the additional responsibilities of breastfeeding and childcare associated with a new baby.

However, it's important to note that excessively prolonged intervals between births, exceeding 59 months, can also pose significant health risks. These include an elevated likelihood of complications such as preeclampsia, labour dystocia, hemorrhage, and obstructed labour, as evidenced by research from Bauserman et al. (2020), Conde Agudelo et al. (2007), and Fotso et al. (2013). As such, while considering extended birth intervals, one must carefully evaluate to avoid potential health issues.

We consider two measures of birth spacing: the percentage of non-first births occurring before and after a 24-month gap following the preceding birth, and the median interval between births. Figure 14 illustrates how we categorize the distribution of second and subsequent births within the five-year period leading up to the survey based on the elapsed months since the last birth, considering refugee status.

The data explained in Figure 14 reveals that (13.7%) of non-first births among refugees follows within 24 months subsequent to the previous birth. Additionally, 41.3% of births among refugees take place between 24 and 35 months, 19.1% between 36 and 47 months, and 18.4% occur after a span of 48 months (four or more years).

Figure 14: Birth Intervals in Months since preceding birth (%)



In general, as people get older, they tend to have more time between having children. But, for refugee women, this time doesn't change much. They usually wait about 34 months between babies. Women who are 40-49 years old wait a bit longer, about 35 months. In the host community, younger women aged 20-29 years have babies every 33 months, but older women aged 40-49 years wait about 41 months. In the entire country, the time between babies for women aged 40-49 years is about 42 months, which is 17 months more than the time for younger women aged 15-19 years, who wait about 25 months.

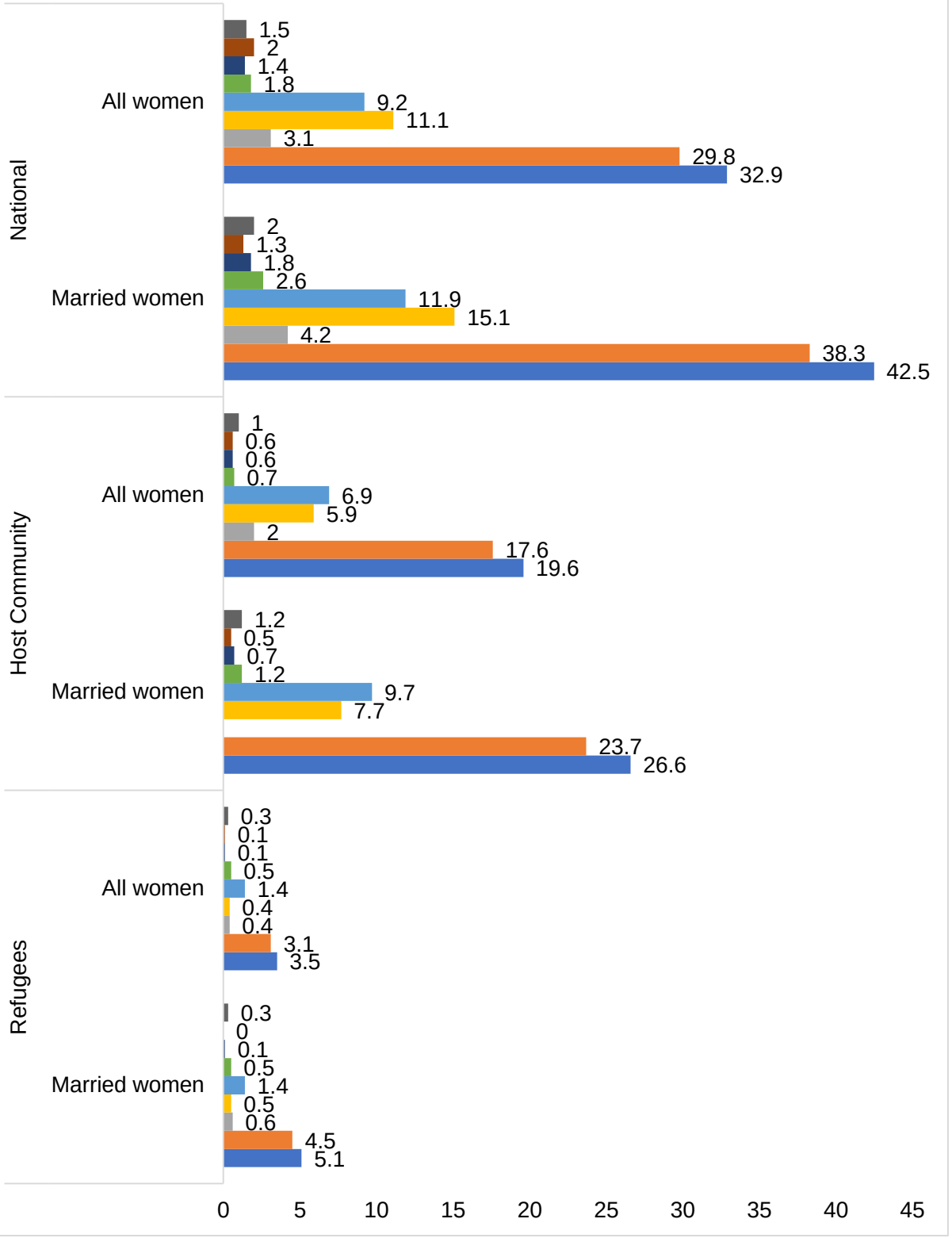
3.11 FAMILY PLANNING

Acquiring knowledge about contraceptive methods is an essential step towards gaining access to family planning services and adopting a suitable contraceptive method. One of the critical steps to accessing family planning services and choosing a suitable contraceptive method is to gain knowledge about different contraceptive options. Almost all women in refugee settlements have heard of at least one contraceptive method, with a knowledge rate of over 99% (not indicated in the chart).

However, the use of family planning methods in refugee settlements is very low. Only 4% of all women and 5% of currently married women aged 15-49 use any contraceptive method (Figure 15). These rates are much lower than those of the host community and the national population, which are 30% and 42%, respectively, for currently married women.

Regionally, the West Nile and South West regions report lower usage rates (3.6% and 2.9%, respectively). The type of method used also varies significantly. For instance, while 15% of the general population use injectables, only 1% of refugees and 7.7% of the host community use them. Similarly, the use of long-acting methods such as IUDs and implants is rare in refugee settings. Previous research indicates that such permanent methods are generally unavailable in displacement settings (Tanabe et al., 2017). This evidence together with the chart underscores the need for targeted interventions to improve contraceptive access and education, particularly among marginalized groups like refugees.

Figure 15; Perentage distribution of all women and currently married women aged 15-49 by contraceptive method currently used, UDHS 2022



A possible factor for refugees' low uptake of family planning services is the lack of awareness and access to family planning information. While radio is the primary medium for disseminating family planning messages in Uganda, only a third of refugees have heard such messages on the radio in the last few months, compared to two-thirds of the national population (Figure 16). Other media sources, such as television or newspapers, are even less available for refugee women. Only 3.4% of refugee women have received a family planning message on their mobile phone, versus 8% nationally. The chart also indicates that two-thirds of refugee women and less than a third nationally have not encountered family planning messages through these four media channels in the last few months.

Figure 16: Exposure to family messages in the past few months,women aged 15-49 years(%).

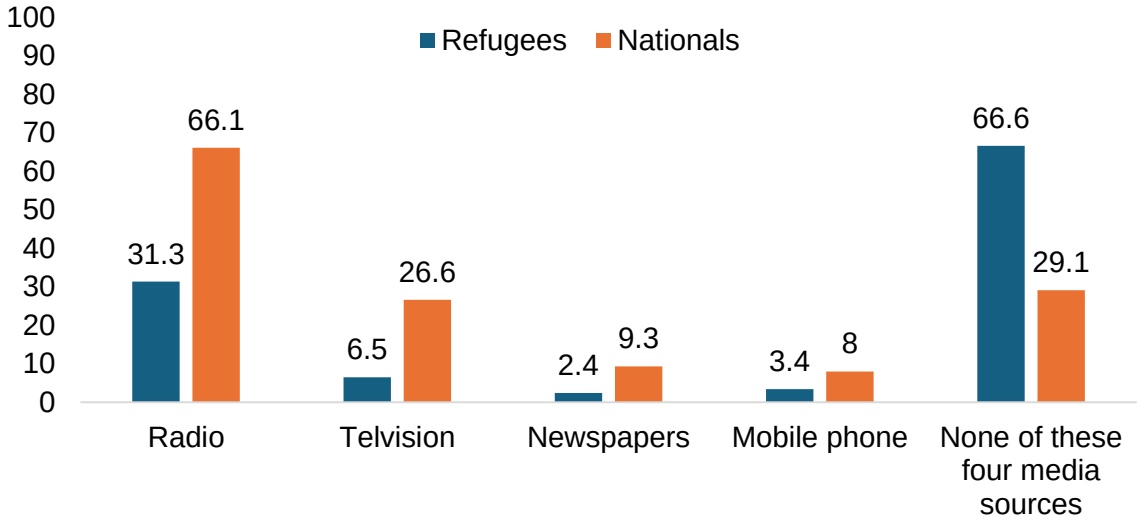
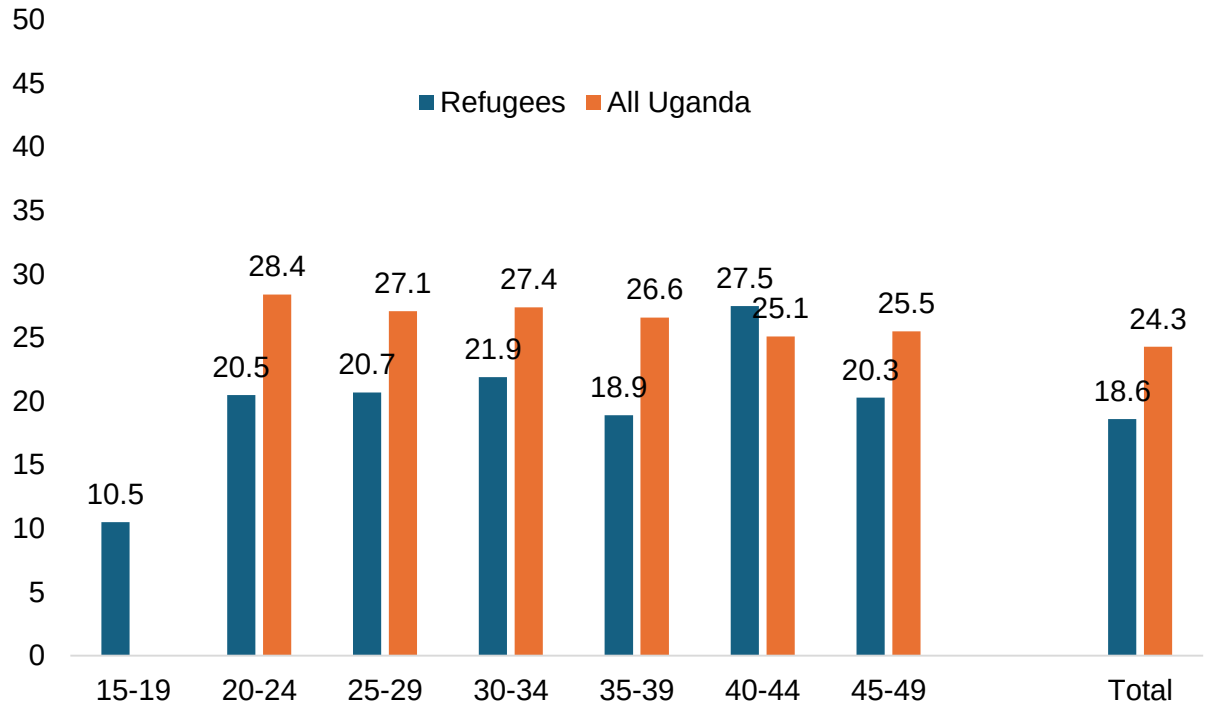


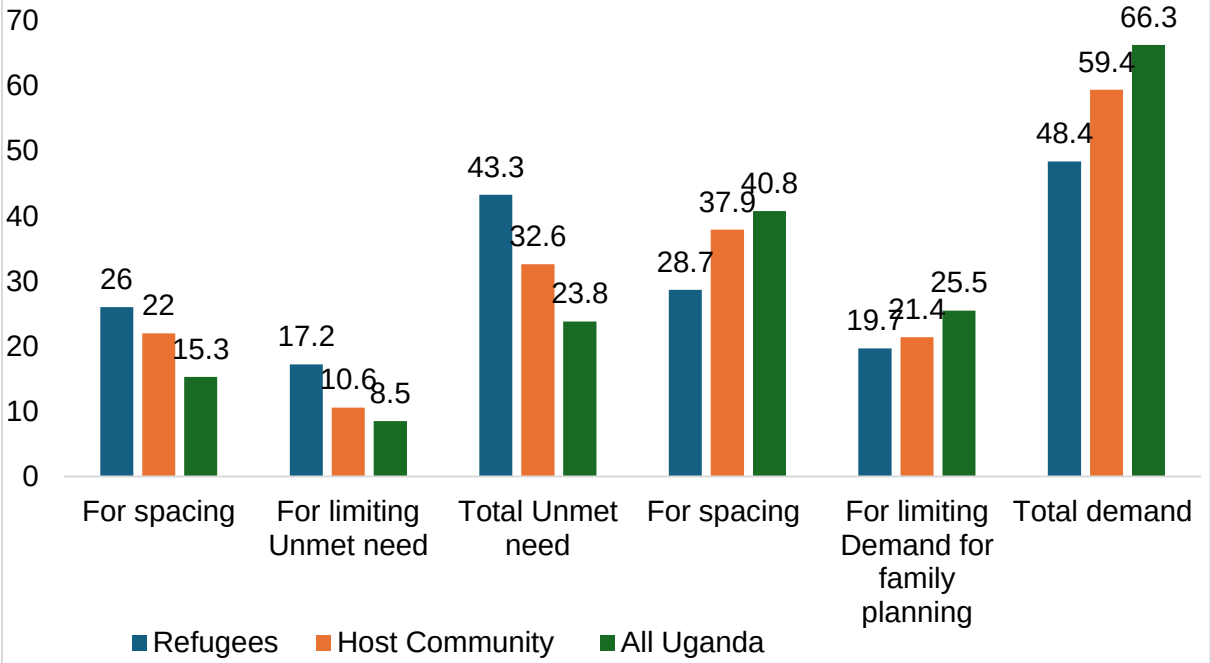
Figure 17 reveals that knowledge of the fertile period among women aged 15-49 varies significantly by age and refugee status. Overall, only 24.3% of women in Uganda possess correct knowledge of their fertile period, defined as "halfway between two menstrual periods," with refugees at 18.6%. Notably, the highest awareness (28.4%) is found among the nationals aged 20-24. while the lowest is in the 15-19 age group (10.5% for refugees).

Figure 17: Percentage of women age 15-49 with correct knowledge of the fertile period during the ovulatory cycle according to age, UDHS 2022



Forty-three percent of currently married women among refugees had an unmet need for family planning, 26 percent had an unmet need for spacing, and 17 percent had an unmet need for limiting. However, the unmet needs among the refugees are nearly double those of the host community (43% vs 33%). Nonetheless, most of the unmet need is for spacing, just like in the general population. A comparison between refugees and the host community (**Figure 18**) shows that the total demand for family planning is significantly lower among the refugees compared to the rest of the population driven by spacing.

Figure 18: Need and demand for family planning among currently married women.



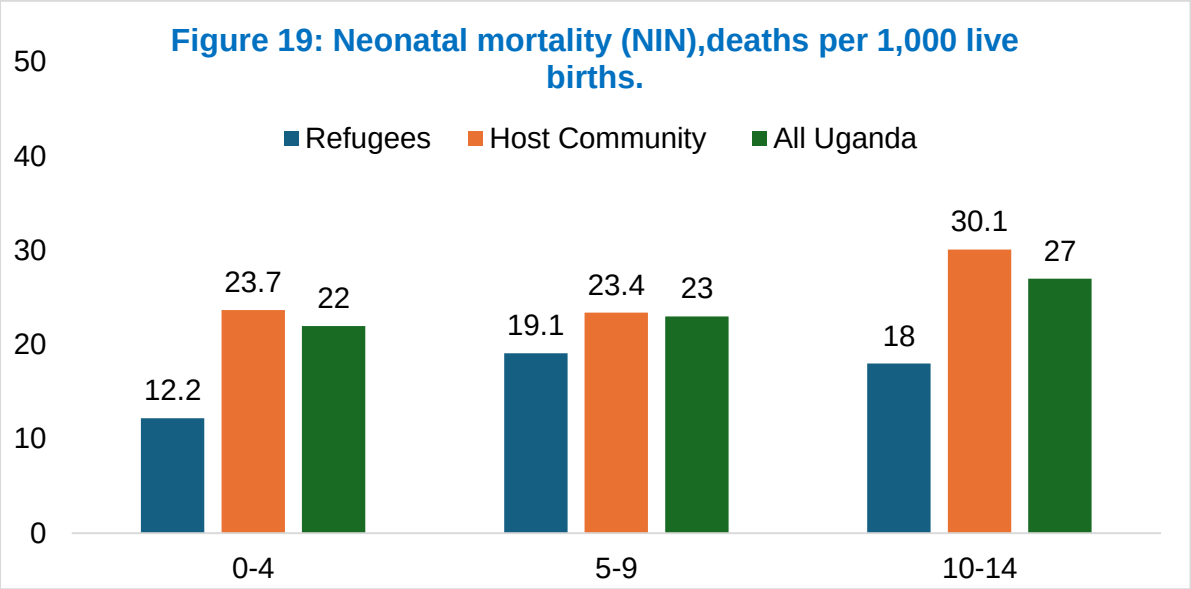
3.12 INFANT AND CHILD MORTALITY

3.12.1 NEO NATAL MORTALITY

Refugees exhibit a lower incidence of neo-natal mortality within the initial month of life. As depicted in Figure 19, the Neo-Natal Mortality Rate for offspring born in the preceding five years stands at merely 12.2 fatalities per 1000 live nativities among refugees. This figure contrasts with 23.7 deaths per 1000 live births within the host community and an overall national rate of 22 deaths per 1000 live births.

Several factors contribute to the lower mortality rates observed among newborns in refugee populations within their first month of life. Targeted health interventions by humanitarian organizations are a primary factor. These organizations recognize the unique challenges faced by displaced populations and often implement specialized health initiatives. Such efforts may include enhancing neonatal care practices both within health facilities and in the broader community. For instance, Tappis (2021) highlights the impact of improved care practices on neonatal outcomes.

Furthermore, comprehensive community-based surveillance systems are more viable within the confines of refugee settlements compared to other widely dispersed populations. These systems are crucial for monitoring neonatal survival and reducing the incidence of stillbirths, as noted by Amsalu et al (2022). The focused nature of these interventions and surveillance systems facilitates a more effective response to the healthcare needs of newborns in these vulnerable communities.



For births occurring 5-9 years prior to the survey, the neonatal mortality rate among refugees was significantly higher at 19.1 deaths per 1000 live births, yet still lower than that of the host community. Notably, the neonatal mortality rate for the host community and the entire country is relatively consistent at 23 deaths per 1000 live births for both recent births and those 5-9 years ago. This consistency shows that there has been no substantial change in neonatal mortality rates within these demographic groups over the past decade.

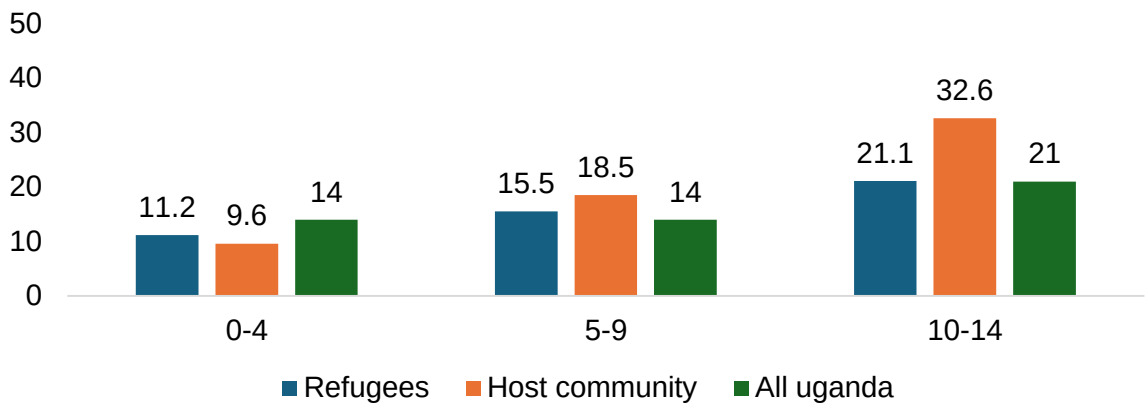
For births occurring in the last 10-14 years preceding the survey, the neonatal mortality rate (NNM) for refugees remains comparatively low at approximately 18 deaths per 1000 live births. This figure is notably less than that of the host community and the country overall. However, it's important to note that the rates for both the host community and the entire country have seen a significant increase for this specific duration compared to the 5-9 years preceding the survey. This shows considerable progress in reducing neonatal mortality over the past decade and a half.

Extensive research shows that neonatal mortality rates (NMRs) within refugee populations, particularly in well-established camps, tend to be lower than those in the surrounding host communities. This phenomenon, as documented by Tappis et al in 2021, may be attributed to the superior healthcare services accessible to refugees. Comparative studies, such as those by Genko et al (2018) in Kenya and Mekonnen et al (2019) in Ethiopia, have demonstrated that health services in UNHCR-supported refugee camps often exceed the quality and reach of those available to the local host country residents. This significant contrast underscores an urgent need for enhanced initiatives aimed at elevating healthcare accessibility and standards in areas grappling with humanitarian crises.

3.12.2 POST NEO NATAL MORTALITY

Figure 20 illustrates the varying post-neonatal mortality rates, which refer to deaths occurring one month after birth. The data does not reveal a consistent trend. For instance, in the 5 years leading up to the survey, the rate among refugees was 11.2 per 1000 live births, marginally lower than the host community's rate of 9.6 deaths and the national average of 14 deaths. Looking at births from 5 to 9 years prior to the survey, refugees experienced a lower mortality rate (15.5 deaths) compared to the host community (18.5 deaths), aligning closely with the national rate. Notably, for deaths occurring 10-14 years before the survey, refugees had a significantly lower rate (21.1 deaths) than the host community (32.6 deaths). The chart shows that over the past 15 years, the host community has achieved remarkable progress in reducing post-neonatal mortality.

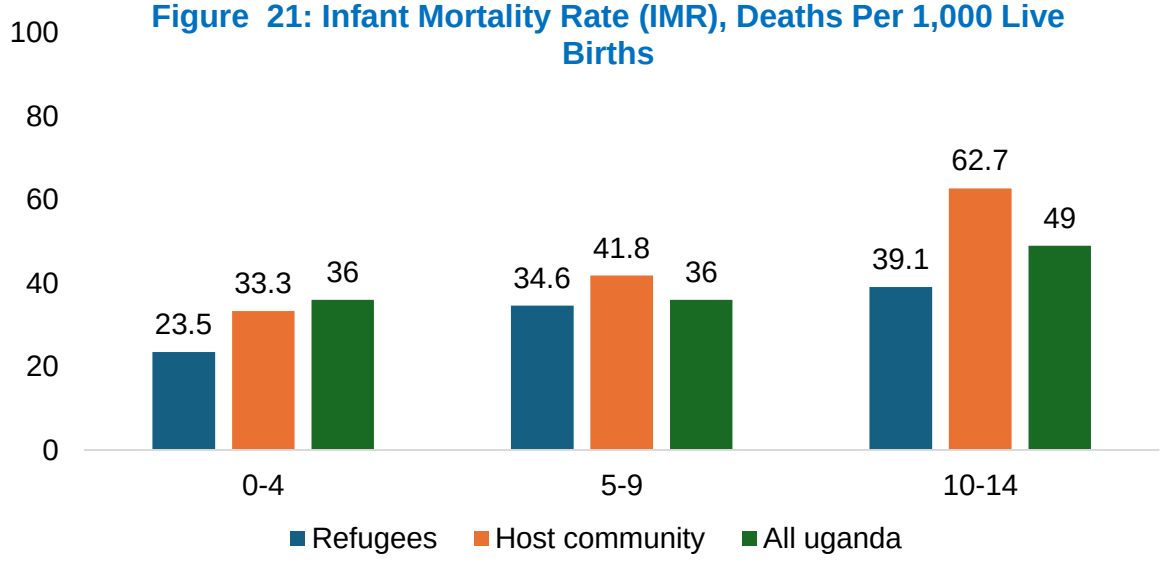
Figure 20: Post Neonatal Mortality (PNN), deaths per 1,000 live births



3.12.3 INFANT MORTALITY

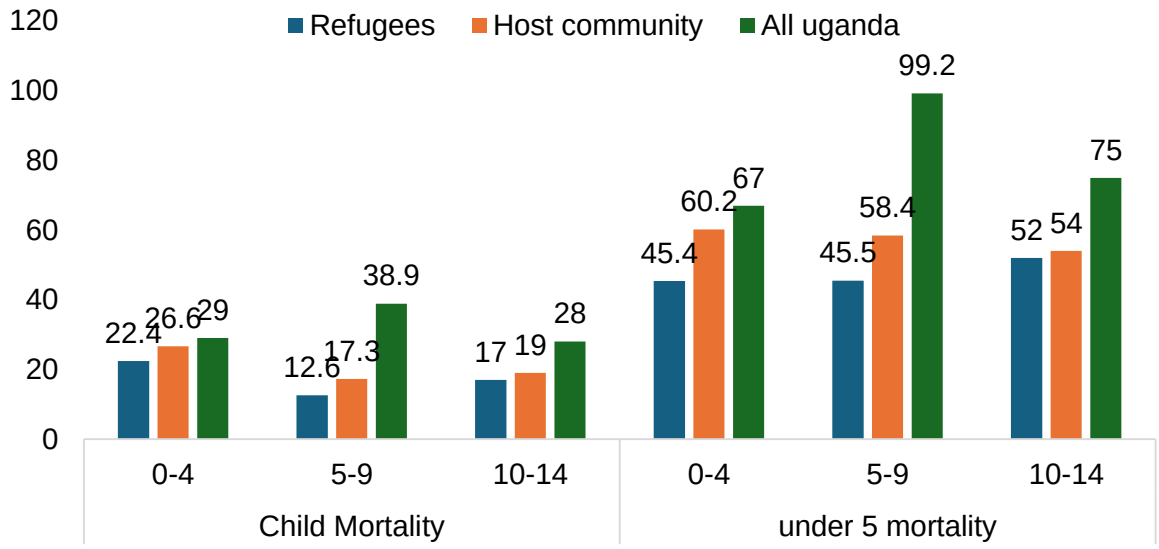
Figure 21 illustrates the infant mortality rates (IMR) segmented by age groups: 0-4 years, 5-9 years, and 10-14 years prior to the surveys. The IMR captures both neo-natal and post-natal mortality figures. Notably, the refugee population has seen most of its reduction in child deaths within the last 5 years. Conversely, the host community experienced a significant decline in child mortality primarily over the past 15 years, transitioning from the 10-14 year to the 5–9-year period before the survey. This trend mirrors the national progress, where most advancements were made over a decade ago.

Figure 21: Infant Mortality Rate (IMR), Deaths Per 1,000 Live Births



The final chart presents a comparative analysis of child mortality rates, which denotes the likelihood of death between the first and fourth birthdays, and under-5 mortality rates, indicating the chances of dying before reaching five years of age (Figure 22). The data reveals a marked reduction in childhood fatalities over the last 15 years as per the surveys conducted. Notably, the host community has witnessed the steepest decline, with under-5 mortality rates halving during this period. When examining refugee populations, the majority of improvements have been observed in infants under one-year-old.

Figure 22: Child Mortality and Under -5 Mortality



Overall, the charts indicate a significant decline in child mortality rates within the host community, concurrent with refugee arrivals. Tappis et al. (2021) provide insights into possible explanations for this trend. Initially, refugee influxes may bring enhanced health education and awareness, with beneficial information permeating into the host community, leading to improved health practices and subsequently, a reduction in early child fatalities. Additionally, the economic stimulation from refugee settlements may elevate living standards and healthcare accessibility for the host community. Lastly, the host community's health outcomes may benefit from infrastructure advancements such as better roads and water facilities, stemming from refugee settlement establishment.

In summary, as indicated in **Table 21a and Table 21b**, child mortality ratios differ significantly among refugees, host communities, and the general Ugandan population. One notable finding is that refugees have a much lower probability of dying in the first month of life than the other two groups. For instance, in the last five years, the neonatal mortality rate was 12.2 deaths per 1000 live births among refugees, compared to 23.7 deaths among host communities and 22 deaths among the general population. This may be because refugees have a lower prevalence of teenage pregnancy, which is 13% compared to 23.5% in the general population. According to UNFPA (2021), adolescent pregnancies account for 20% of infant deaths in Uganda.

Mortality rates for children under five show significant variation depending on the mother's age at birth. Children born to mothers younger than 20 face elevated mortality risks compared to those born to mothers in their 20s and 30s. The neonatal mortality for refugees is 18 deaths per 1000 live births compared to 30 deaths per 1000 live births for both the host community and all Uganda.

Mortality rates also vary significantly according to birth order, following a pattern where first-born children and those of very high birth order (7+) face higher risks than children of intermediate birth orders (2-6). Specifically, first-born children (Birth Order 1) show a notably high neonatal mortality rate compared to other birth orders, except for the highest order births in the general population. For this particular demographic group, the neonatal Mortality is 20.6 for refugees and 16.0 for all of Uganda. On the other hand, children of Birth Order 7+ face dramatically elevated mortality risks, especially within the general Ugandan population.

Overall, the table shows a J-shaped mortality curve related to birth order: the risk is high for the first child, decreases for the second to sixth children (with some variations), and then rises sharply for the seventh child and above. The bottom section of **Table 22b** shows that children born into the wealthiest households have a substantially higher chance of survival through their first five years of life compared to those born into the poorest households.

Moreover, the 2022 UDHS reveals that among the host communities, adolescents have a neonatal mortality rate of 39.5 deaths, while women aged 20-29 years have a rate of 19.9 deaths. However, the refugee advantage diminishes after the first year of birth, as refugees have much higher child mortality rates than the host and the general population. The table also shows that mortality rates have declined over time, thanks to improvements in healthcare, nutrition, and immunisation campaigns. Finally, the table shows that the host community has experienced a remarkable reduction in under-5 mortality in the past 15 years, from 99 deaths to 45 deaths per 1000 live births; this may be because of their access to health services.

3.12.4 HIGH RISK FERTILITY BEHAVIOUR AND CHILD MORTALITY

Studies show a connection between a mother's age and pregnancy timing and the risk of a child dying young. Children are more likely to die if their mother is very young, e.g. under 18, or older than 34, if they were born too soon after their sibling, or if their mom has had lots of babies. Adolescents undergoing pregnancy and childbirth face heightened complications due to their incomplete physical development. Conversely, advanced maternal age can lead to complications inherent to that life stage. To analyse high-risk fertility behaviour, we classify 'too young' to refer to mothers under 18 years of age, while 'too old' encompasses those over 34 years at childbirth. Additionally, a 'short birth interval' means a mother has a baby less than two years after her last one.

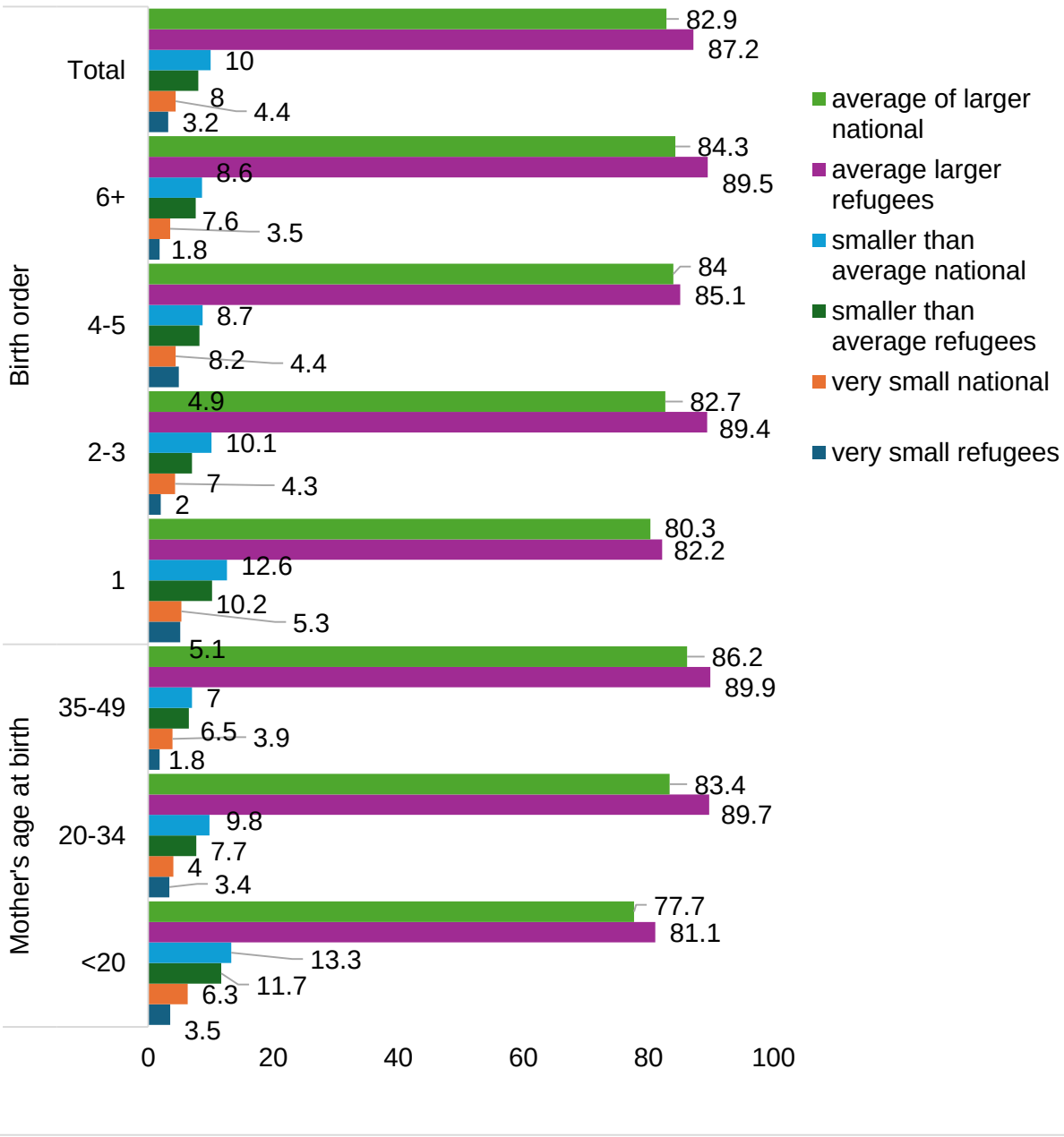
Table 19 illustrates the comparative analysis of child mortality risks between refugee births and national averages over the past five years. According to the comparative analysis of child mortality risks between refugee births and national averages over the past five years, 59.2% of refugee births are categorized as high mortality risks that can be prevented, while 8.6% fall into a single high-risk category. In contrast, the national figures stand at 60.9% and 37.5%, respectively. Furthermore, a minimum of 29.1% of births among refugees are free from any high-risk categories, which is marginally higher than the national percentage of 23.9%.

3.12.5 BIRTH WEIGHT

A child's birth weight or size at birth is a critical measure of newborn health and a predictor of future development outcomes. Low birth weight, defined as less than 2.5 kilograms or children reported to be 'very small' or 'smaller than average, are associated with a host of developmental challenges and a higher risk of early childhood mortality. Figure 23 compares children's birth size for refugees and the national population.

Figure 23 suggests a correlation between maternal age and birth weight, with infants born to younger mothers, particularly those under 20, being more susceptible to low birth weight. Specifically, younger mothers under age 20 are more likely than women aged 35-49 to have infants classified as smaller than average (13.3% and 7%, respectively). This trend is also observed in first-born children compared to their later-born siblings. The decrease in the incidence of low birth weight with increasing maternal age and birth order may be attributed to a variety of factors, including physiological maturity, accumulated parenting experience, and possibly improved socioeconomic conditions.

Figure 23: Distribution of all all live births by child at birth, (%)



3.13 MATERNAL HEALTH

Table 20 shows the antenatal care (ANC) provider distribution among refugees and the general population in Uganda, highlighting disparities based on residence, education, and wealth. Almost all (96%) women aged 15-49 who had a live birth in the two years preceding the survey received antenatal care from a skilled provider at least once for their most recent birth. The table reveals that 89.2% of refugees receive ANC from nurses/midwives doctors, while only 5.4% receive from doctors.

Urban refugees show a higher reliance on nurses/midwives (88.5%) compared to the general Ugandan population (80.2%). Educational attainment significantly impacts ANC access, especially from doctors, with only 4.1% of refugees with no education receiving care from doctors, versus 22% among the highest education level. Individuals with no education have the highest rates of no access to ANC, both refugees and general population. Wealthier quintiles also demonstrate varied access, with the lowest quintile having only 2.8% receiving care from doctors.

Table 22 shows the distribution of antenatal care visits among refugees and the general population in Uganda. Majority of expectant mothers make the minimum expected antenatal visits. At least 3 out of every four refugee mothers undertake 4 antenatal visits compared to 67.8% for the general population. Regionally, among the refugee population, West Nile and South West showed similar trends, with 80% and 73.7% of refugees reporting 4+ visits, respectively.

Table 23 shows the timing of first antenatal care (ANC) visits among refugees and the general population in Uganda, highlighting disparities based on residence, education, and wealth quintile. Notably, 56.2% of urban refugees attended ANC when they were less than 4months pregnant, compared to 40.2% of all Ugandan women. Rural refugees showed lower early ANC engagement, with 49.9% visiting at less than 4 months pregnant. Among refugees, educational attainment significantly influenced ANC timing; 9.2% of women with no education had no ANC visits, while only 1.1% of those with secondary education had no ANC visits at all.

Labour and delivery is the shortest and most critical period of the pregnancy-childbirth continuum because most maternal deaths arise from complications during delivery. Even with the best possible antenatal care, any delivery can become complicated; therefore, skilled assistance is essential to safe delivery care. **Table 24** shows that approximately 96% of live births in the 2 years before the survey were delivered in a healthcare facility. Health professionals acknowledge the critical importance of obstetric care during delivery in reducing maternal and neonatal mortality. A skilled health professional assisted in about 98% of births in refugee settlements.

Table 24 highlights the disparities in childbirth location preferences between refugees, host communities, and the general population over the past two years. Notably, 96.3% of refugee women opted for health facilities during childbirth, surpassing the 88% of host community women and 86.4% of the general population.

This trend echoes findings from Tappsi et al., 2021, suggesting that refugee settlements often have improved access to healthcare services and infrastructure. However, it's also observed that refugees predominantly utilize public sector facilities for childbirth, while private health facility usage is more prevalent among the general population, at 12.5%, compared to a mere 5.7% within host communities. In contrast to refugees, a considerable segment of both host community members and the general populace (11% and 12.9%, respectively) still prefer home births.

The analysis delves into the correlation between maternal education and the location of childbirth, along with the attendant provider. Among refugees, the educational level seems inconsequential for choosing the birthplace; over 95% of refugee women utilize health facilities for childbirth irrespective of their educational background. Similarly, the host community does not show any significant difference, with 82% of women opting for public sector facilities for delivery. Contrastingly, in the general populace, maternal education significantly influences the choice between private and public sector facilities for childbirth.

Notably, higher educational attainment correlates with a greater propensity to choose private facilities. Precisely, 24.2% of women holding an education level above secondary school prefer private facilities for delivery, as opposed to 18.4% with only secondary education and roughly 9.6% with primary education. This pattern indicates that maternal education and household wealth may act as interchangeable factors in this context. Considering the high volume of facility-based births, Table 20 further highlights that a skilled provider assists the majority of these women during childbirth.

3.14 CHILD HEALTH

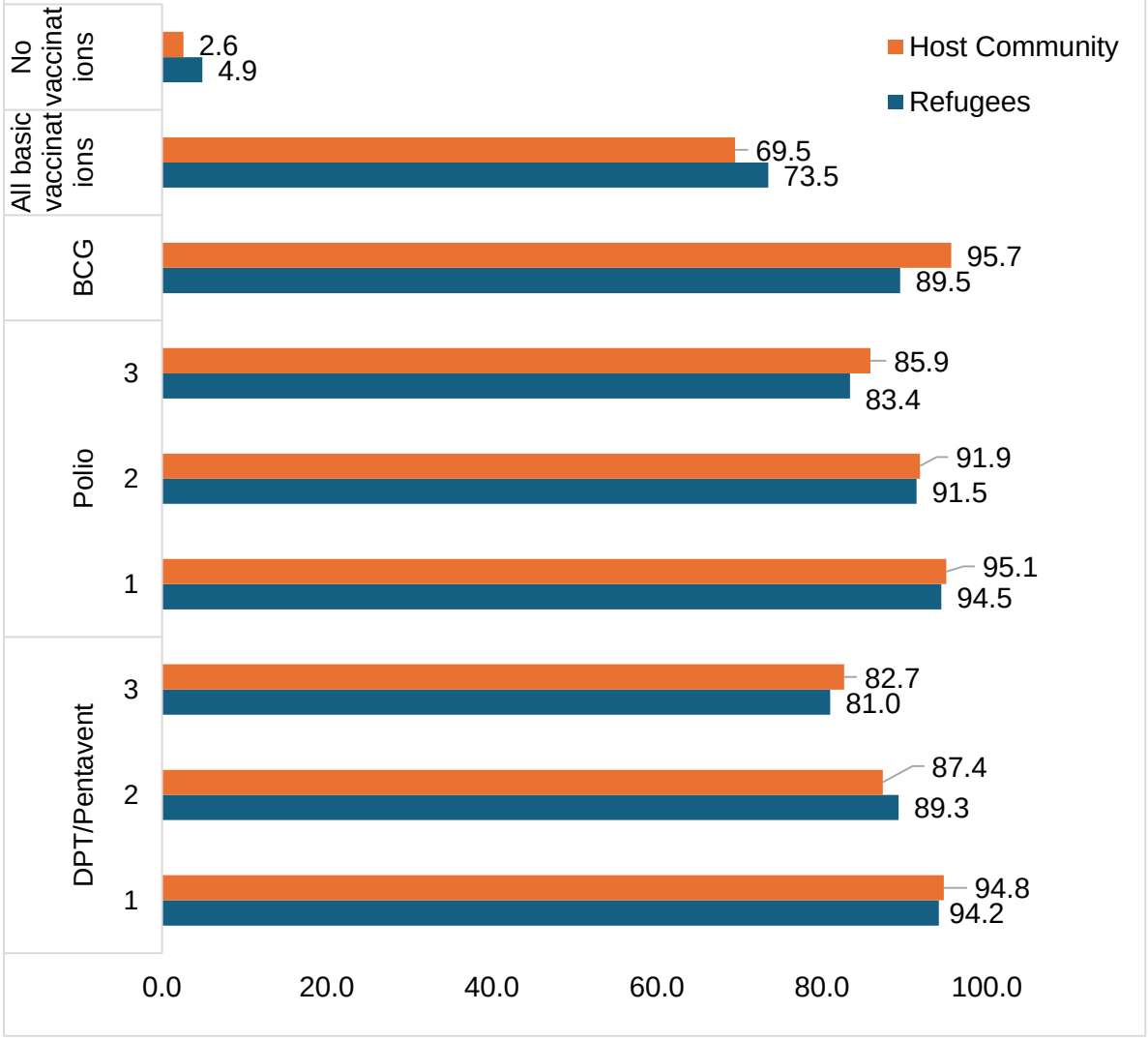
3.14.1 VACCINATIONS

Universal immunisation of children against common vaccine-preventable diseases is crucial in reducing infant and child morbidity and mortality. The routine childhood vaccines include Bacillus Calmette Guérin (BCG) (tuberculosis); Oral Polio Vaccine (OPV) and Inactivated Polio Vaccine (IPV); pentavalent or DPT-HepB-Hib (diphtheria, pertussis, tetanus; hepatitis B; and Haemophilus influenza type b); pneumococcal conjugate vaccine-10 (PCV10); Rotavirus Vaccine (RV); and Measles-Rubella (MR) vaccine.

The information presented in Figure 25 is for children aged 12-23 months, the youngest cohort of children who had reached the age by which they should have had the basic vaccines and restricted to children who were alive at the time of the survey. It compares the vaccination coverage of children aged 12-23 months among refugees and the host community. The data shows that most children in this age group have received vaccinations regardless of their displacement status.

For instance, the differences in DPT and polio vaccination rates are negligible among the two groups. However, a notable gap emerges for measles, where refugees have a much higher vaccination rate than the host community or the general population. Moreover, refugees have the highest rate of basic vaccinations at 73.5%, above 69.5% of the host community and 63% of the general population.

Figure 24: percentage of children aged 12-23 months vaccinated



3.14. 2 FEVER

Table 25 shows that the prevalence of fever is significantly lower among refugee children compared to the rest of the country with at least 18.1% of children under five among refugee households report fever during the past two weeks compared to 23.4% for the whole of Uganda.

The regional distribution of malaria could explain the divergence, that is, a lower share of children report fever in the West Nile sub-region which is the main refugee-hosting sub region. Specifically, only 12.6% of refugee children report fever compared to 37% for the country.

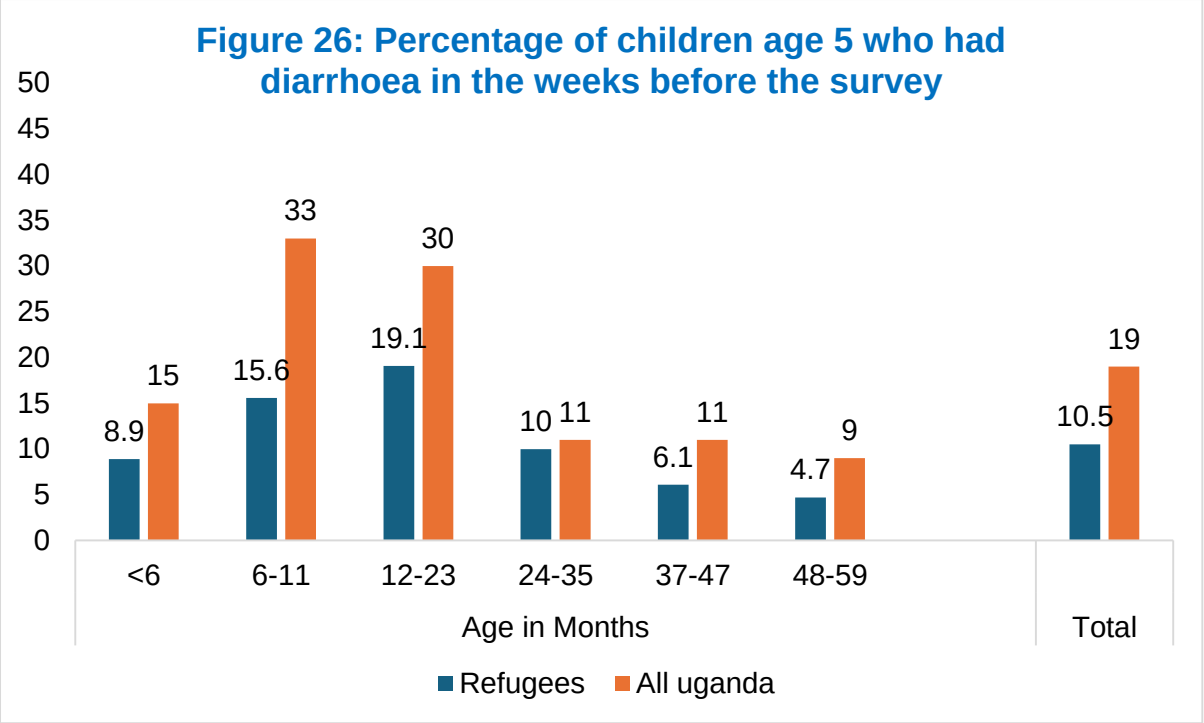
Additionally, refugee settlements generally reported slightly better malaria prevention outcomes. For example, the 2019 Uganda Malaria Indicator Survey showed that the use of malaria nets was higher among refugee settlements than in the general population. Specifically, the 2019 MIS showed that 78.4% of children in refugee settlements used existing Insecticide Treated Nets (ITNs) the previous night, compared to 68.7% in the general population (UBOS and ICF, 2020).

The table also shows that the proportion of children taken for advice or treatment is high at 86.5%. Furthermore, the table shows that at least 54% of refugees and 51% of the general population promptly sought advice or treatment on the same or the next day. Ten percent of children with a fever received antibiotics, with refugee children from Ankole receiving a higher dosage of antibiotics compared to the general population.

3.14.3 DIARRHOEA DISEASE

The widespread occurrence of diarrhoea in children under five is often linked to the use of contaminated water and poor sanitation practices, including inadequate food preparation and disposal of excreta. The 2022 UDHS sought to address these concerns by collecting data from mothers on the incidence of diarrhoea in their children and their subsequent management practices. This included questions about feeding during episodes of diarrhoea and the methods used to dispose of children's faecal matter, which are critical factors in controlling the spread of the disease.

The data presented in Figure 26 offers a snapshot of the health disparities affecting children under five in Uganda. It highlights a significant difference in the incidence of diarrhoea between refugee children and the general child population, with refugee children experiencing a lower rate of 10.5% compared to 19% for the national average. This difference in the incidence of diarrhoea between refugee children and the general child population could be attributed to various factors, including possible variations in living conditions, access to clean water, and healthcare services.



The age-specific analysis in Table 25 reveals that the youngest children, particularly those between 6-23 months, are at higher risk, which underscores the importance of targeted interventions for this vulnerable age group. The correlation between socio-economic status and health is evident, as the prevalence of diarrhoea decreases with higher wealth quintiles and improved maternal education. These insights can inform public health strategies, emphasizing the need for improved sanitation, healthcare access, and education to mitigate the risks of diarrhoeal diseases among children in Uganda.

Treatment of Diarrhoea

The second panel of **Table 26** highlights the healthcare-seeking behaviour of mothers for children suffering from diarrhoea, which is a critical indicator of community health engagement and access to medical services. About 80% of refugee children and 69% of children from the general population with diarrhoea sought advice or treatment from a health facility or provider. The fact that a large percentage of children are taken to health facilities for treatment shows that caregivers are actively addressing illnesses, which is important for preventing complications related to diarrhea.

The child's age plays a significant role in the likelihood of seeking treatment, with the highest percentages observed in specific age brackets for refugees and the general population. Specifically, children aged 12-23 months among refugees and aged 36-47 months among the general population were more likely than children in other age groups to be taken for treatment (86.8% and 71.0%, respectively). This could be because refugee parents possibly have better access to health facilities. On the other hand, the table reveals minimal gender disparity in treatment-seeking behaviour and suggests equitable health practices regardless of the child's sex.

Feeding Practices during Diarrhoea

Managing diarrhoea in children is considered a critical aspect of child healthcare by healthcare providers, especially in settings where access to medical services may be limited. The 2022 UDHS provides valuable insights into the practices mothers adopt during diarrhoea episodes in their children. The survey highlights the importance of maintaining or increasing fluid intake to prevent dehydration, which can severely affect a child's health. There is a disparity in practices between refugee children and the national average, with a higher percentage of refugee children receiving more fluids than usual during diarrhoea episodes. Specifically, **Table 27** shows that caretakers gave more fluids than usual to 32.6% of refugee children with diarrhoea, as recommended, while 28.6% of refugee children who had diarrhoea were given the same amount of liquid as usual.

The corresponding rates nationally are 18.1% and 34.5% respectively. This suggests a positive adherence to recommended practices within refugee communities. One out of every five refugee children who had diarrhea received no liquids (24.9%), while the national rate was much lower at 15.4%. This raises a concern with the significant percentage of children who received less or no fluids, emphasizing the need for continued education and support to ensure all children receive the care needed to mitigate the impacts of diarrhoea in their nutritional status and overall health.

The feeding practices for children with diarrhoea reveal significant disparities between refugee and national populations. Table 27 shows that refugee children are more likely to receive more food than usual compared to national children. This could be indicative of the different health management strategies or availability of resources in refugee settings. On the other hand, in refugee settings, health management strategies or resource availability might result in a smaller proportion of refugee children being given less food than usual during illness, suggesting a protective response against the potential risks of malnutrition.

The data also highlights the influence of socio-economic factors on health practices, such as the level of maternal education and wealth status, which appear to affect the likelihood of children receiving adequate nutrition and hydration during episodes of diarrhoea. These insights are crucial for informing public health interventions and ensuring that all children, regardless of their background, receive the care necessary to support their recovery and overall well-being during such vulnerable times.

Stool Disposal

The proper disposal of children's faeces is a critical public health measure to prevent the transmission of diseases, particularly in areas where sanitation infrastructure may be lacking. Improper disposal of children's faeces can lead to the spread of pathogens through direct contact or via animals, contaminating food and water sources. It's a common misconception that children's faeces are less harmful than those of adults, but in reality, they often contain high levels of pathogens due to the frequency of infections in young children.

Safe disposal methods include using a toilet or latrine, rinsing the faeces into a toilet or latrine, or burying them. These practices are essential to maintain a hygienic environment and protect the community's health, especially the health of children who are more vulnerable to fecal-oral diseases. The data presented in Table 28 offers a comprehensive look at the sanitation practices affecting children under the age of five. It highlights a significant aspect of public health concerning the disposal of children's stools, which is a critical indicator of a community's overall sanitation and hygiene practices.

According to the table, most refugee children dispose of their stools in a manner considered safe (76.3%), and a significant number rinse them in toilets or latrines (69.2%). The national average for safe disposal is marginally higher (79.1%), suggesting slight variations in sanitation practices across different demographics, especially the higher rate of burying children's stool (6.5% vs 4.5%). The table also suggests a correlation between the safe disposal of children's stools and factors such as urbanization, maternal education, and household income, which can inform future public health initiatives aimed at improving sanitation standards and practices. Overall, the results show that community education on the importance of these sanitation practices, along with the provision of adequate facilities, plays a vital role in enhancing public health and preventing disease outbreaks.

3.15 NUTRITION

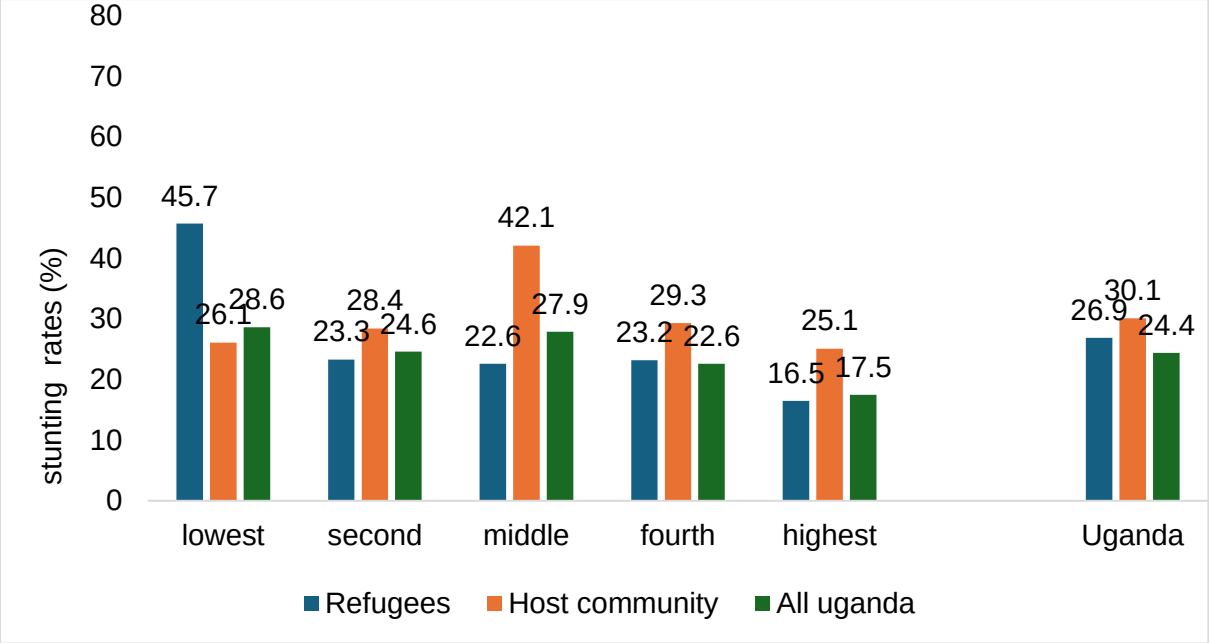
3.15.1 CHILDHOOD NUTRITION

Figure 27 shows the stunting rates which captures whether a child's height for age score is less than 2 standard deviations of reference population by wealth status. Stunting is a long-term measure of nutritional health in which the z-score reflects any sustained experience of inadequate nutrient intake coupled with untreated illnesses, which can cause impaired growth as it is irreversible.

Overall, at least 26.9% of children from refugee households are stunted, but children from host communities have a slightly higher rate of stunting (30.1%). Based on the wealth quintile, children from the bottom quintile from refugee households are about twice as likely to be stunted (44.7%) compared to the host community or general population. Similarly, the stunting rate for the middle quintile among children from the host community (42.1%) is nearly double that of refugees and the general population.

The very high stunting rates among refugee children in the bottom quintile and children from the host community in the middle quintile suggest that, for these children, it may not be possible to correct nutritional deficiencies suffered in height during the first five years of life.

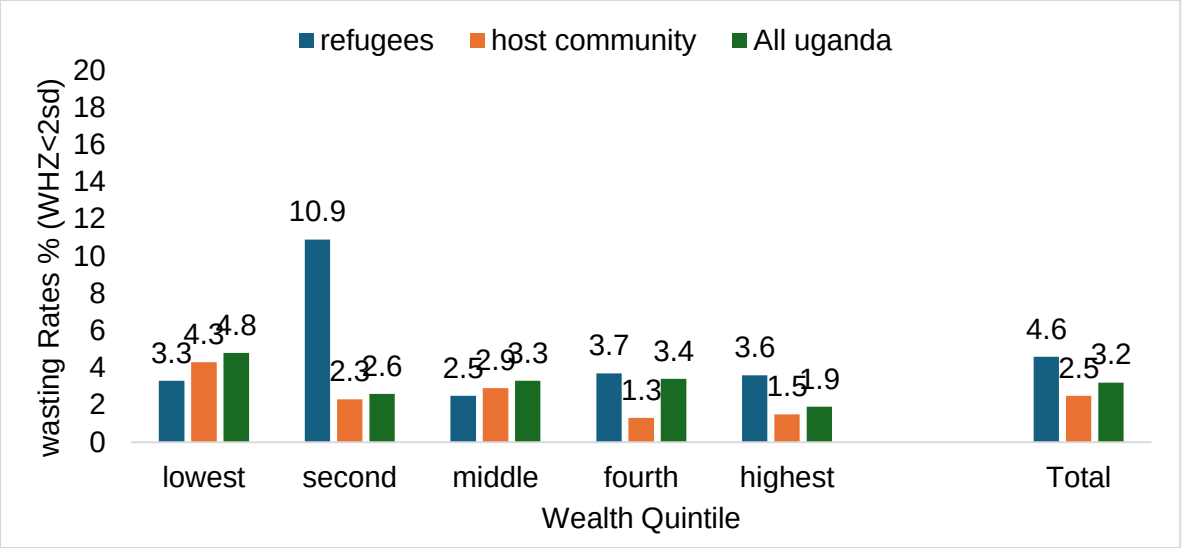
Figure 27: Rates of Stunting among Children



Tables 29 and **Table 30** for refugees and host communities show boys are significantly more likely to be stunted or underweight. This is consistent with findings from other sub-Saharan African countries that show a higher prevalence of stunting among boys (Wamani et al. 2007). The two tables also show that stunting and underweight rates are lower for children whose caretakers have at least secondary education. Higher education attainment may be associated with factors such as dietary diversity and timely access to healthcare.

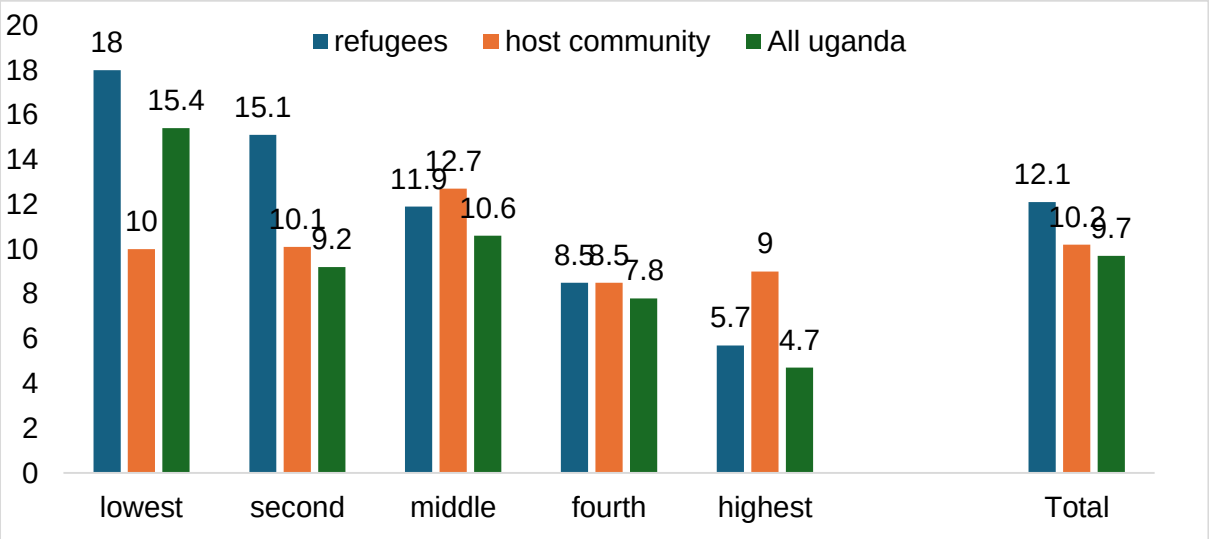
Figure 28 shows the wasting rates by wealth status. These capture whether a child's weight for height z-scores are less than 2 standard deviations below the reference population. Wasting measures acute undernutrition or rapid weight loss and increases a child's infection vulnerability. The chart shows that wasting rates are substantially higher among refugee children (4.6%) compared to the host community or the general population. The distribution by wealth status is skewed to the right, primarily driven by refugee children from the second poorest quintile.

Figure 28 Rates of Childhood Wasting among Children



The final child nutrition indicator considered is underweight rates, which captures whether a child's weight for age z-scores is less than 2 standard deviations of the reference population. It reflects past (chronic) and/or present (acute) undernutrition. As was the case for wasting, Figure 29 shows that underweight rates are slightly higher among refugee children (12%) than children from host communities or the general population (about 10%). Among refugee children, underweight rates decline with increases in wealth status, pointing to the fact that wealthier households can afford diverse diets, leading to better nutrition. Also, more affluent households may have access to better nutrition and sanitation facilities.

Figure 29: Rates of Underweight Status among Children



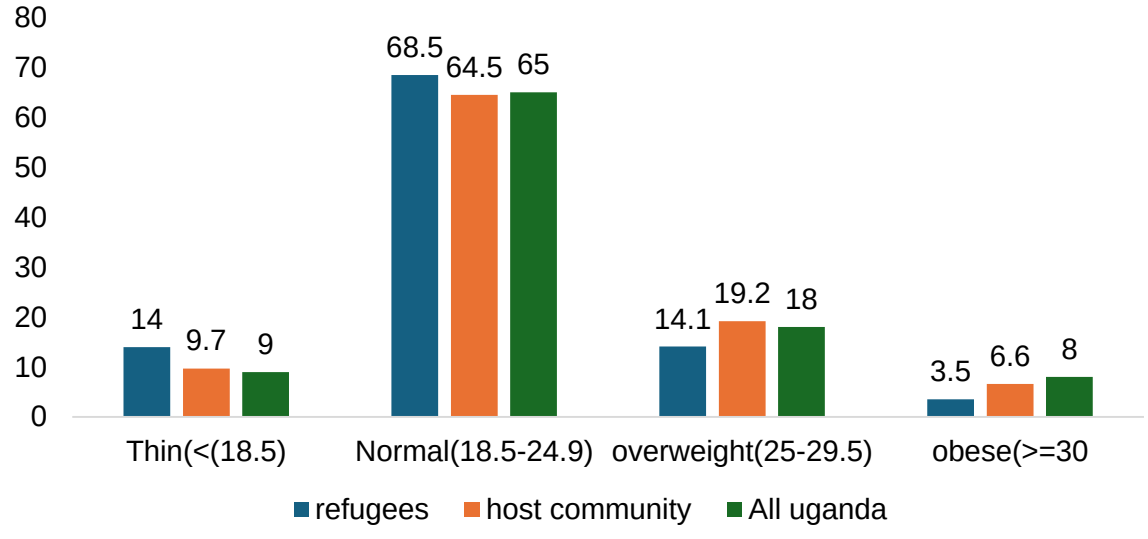
3.15.2 ADULT NUTRITION

For the nutritional status of women, we consider the BMI and measures of the various thresholds of BMI for women aged 15-49 years, shown in Figure 30. The majority of women have a normal BMI, with 68.5% of refugees and 65% of the host community and general population falling into this category. However, there is a significant difference in the proportion of thin women (BMI < 18.5) and those who are overweight or obese among refugees and non-refugees.

Refugee women have a higher prevalence of thinness (14%) and a lower prevalence of overweight, or obesity (14.1%) compared to non-refugee women (9% and 18%, respectively). Various factors, such as poor living conditions, lack of access to nutritious food, and migration-related stress, may contribute to the higher prevalence of thinness and lower prevalence of overweight or obesity among refugee women compared to non-refugee women.

According to the Uganda Refugee and Host Communities 2018 Household Survey, about 54% of refugee households' income comes from aid, mainly through healthcare assistance and in-kind food and household items (World Bank, 2019). In contrast, wages and agriculture account for 24% and 54% of host households' income, respectively. Therefore, refugees may have limited food choices and intake, resulting in a low BMI.

Figure 30: Nutritional status of wowen aged 15-49 years



3.16 FEMALE CIRCUMCISION AND OBSTERIC FISTULA

Figure 31 shows that about 69% of women aged 15-49 had ever heard of female circumcision practices, and 1.3% of women were circumcised. It further shows that thirty-five percent of women aged 15-49 were aware of obstetric fistula, while approximately 1% of the women reported they have ever experienced the problem.

Figure 31: Awareness about FGM and obstetric fistula among women age 15-49 (Percent)

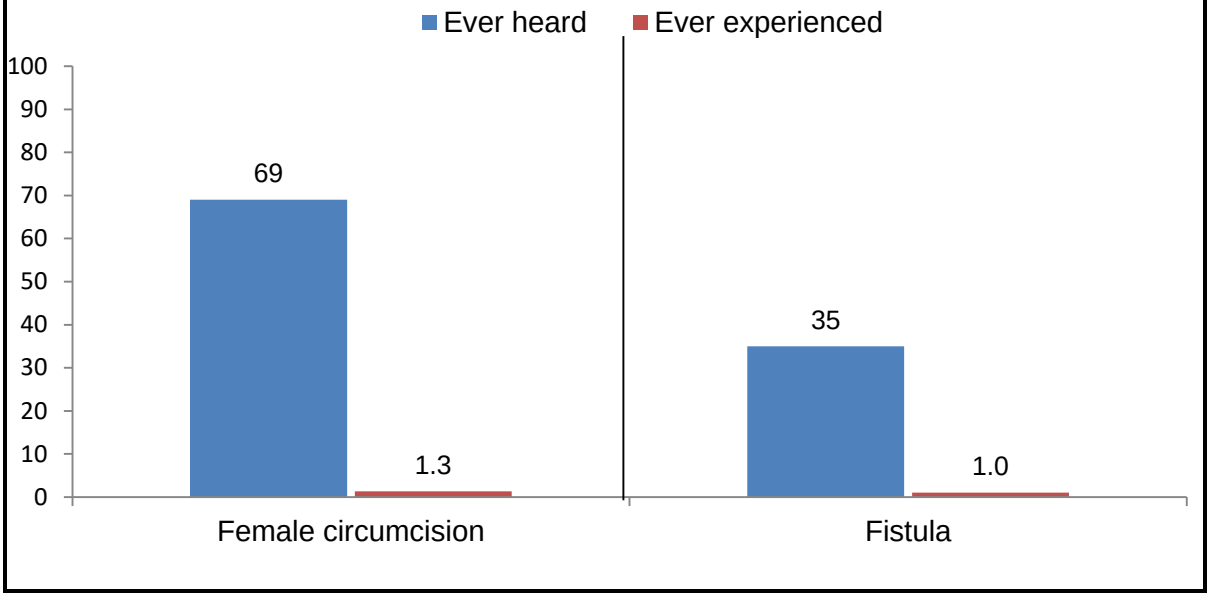


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Table 4: Children's living arrangements and orphanhood

Percent distribution of de jure children under age 18 by living arrangements and survival status of parents, percentage of children not living with a biological parent, and percentage of children with one or both parents dead, according to background characteristics, Uganda DHS 2022

		Living with mother but not with father		Living with father but not with mother		Not living with either parent								
	With both parents	Father alive	Father dead	Mother alive	Mother dead	Both alive	Only father alive	Only mother alive	Both dead	Survival info missing	Total	Child under 18 not living with a biological parent	Child under 18 with one or both parents dead	Number of children
	Refugees													
Age														
0-4	44.1	37.0	5.9	1.5	0.4	6.9	0.5	0.8	0.4	2.3	100	8.7	8.2	2,096
<2	45.4	43.4	4.6	0.8	0.3	2.5	0.2	0.2	0.0	2.6	100	2.9	5.4	774
2-4	43.3	33.3	6.6	1.9	0.5	9.5	0.7	1.1	0.7	2.2	100	12.1	9.8	1,322
5-9	36.0	30.8	10.1	3.1	0.4	10.8	1.2	2.6	2.6	2.4	100	17.2	17.2	2,223
10-14	30.0	27.5	12.2	3.1	1.1	11.7	1.7	5.0	5.0	2.7	100	23.5	25.1	2,196
15-17	25.5	22.5	14.1	3.5	0.8	16.7	2.3	5.6	6.6	2.4	100	31.2	29.8	874
Sex														
Male	34.5	30.2	10.5	2.9	0.5	11.2	1.3	3.1	3.2	2.5	100	18.9	18.9	3,708
Female	36.1	31.0	9.5	2.5	0.8	10.2	1.3	3.2	3.1	2.5	100	17.8	18.0	3,680
Wealth														
Lowest	43.6	26.2	12.8	3.2	0.5	4.4	0.1	1.4	3.0	4.7	100	9.0	18.1	1,463
Second	28.4	36.5	9.9	2.6	0.8	12.3	1.7	2.9	2.8	2.3	100	19.6	18.1	1,523
Middle	30.1	32.2	10.9	2.9	1.2	10.9	1.1	4.0	3.3	3.5	100	19.3	20.7	1,474
Fourth	32.7	31.3	9.7	2.6	0.4	13.0	1.6	4.9	3.1	0.7	100	22.5	19.8	1,479
Highest	41.9	26.4	6.7	2.1	0.4	12.7	2.0	2.7	3.7	1.3	100	21.1	15.6	1,451
Total	**35.3**	**30.6**	**10.0**	**2.7**	**0.7**	**10.7**	**1.3**	**3.2**	**3.2**	**2.5**	**100**	**18.3**	**18.5**	**7,388**

Table 4: Children's living arrangements and orphanhood

Percent distribution of de jure children under age 18 by living arrangements and survival status of parents, percentage of children not living with a biological parent, and percentage of children with one or both parents dead, according to background characteristics, Uganda DHS 2022

		Living with mother but not with father		Living with father but not with mother		Not living with either parent								
	With both parents	Father alive	Father dead	Mother alive	Mother dead	Both alive	Only father alive	Only mother alive	Both dead	Survival info missing	Total	Child under 18 not living with a biological parent	Child under 18 with one or both parents dead	Number of children
	Host Community													
Age														
0-4	62.8	20.3	0.9	3.0	0.5	11.4	0.5	0.2	0.1	0.2	100.0	12.3	2.2	1,609
<2	71.5	23.0	0.5	0.5	0.6	3.4	0.0	0.0	0.2	0.2	100.0	96.4	1.3	599
2-4	57.6	18.7	1.1	4.5	0.4	16.2	0.9	0.3	0.1	0.2	100.0	17.4	2.8	1,010
5-9	48.1	14.7	3.2	7.8	0.6	22.0	0.9	1.7	0.7	0.4	100.0	25.3	7.1	1,718
10-14	42.9	14.9	5.5	8.9	1.2	20.7	1.1	3.0	1.3	0.6	100.0	26.1	12.1	1,598
15-17	40.4	14.0	7.2	7.8	1.9	17.6	1.6	5.7	2.1	1.4	100.0	27.1	19.1	647
Sex														
Male	49.9	16.5	3.6	7.5	1.1	17.2	0.7	2.3	0.7	0.5	100	20.9	8.5	2,818
Female	50.0	16.1	3.7	6.0	0.7	19.0	1.1	1.9	1.0	0.5	100	23	8.5	2,755
Wealth quintile														
Lowest	51.0	15.8	4.0	7.1	0.7	17.8	1.2	1.8	0.3	0.2	100	21.1	8.1	1,145
Second	46.0	21.8	3.8	5.3	1.1	18.4	0.3	1.7	1.3	0.3	100	21.7	8.5	1,106
Middle	52.2	16.0	4.9	4.2	0.3	17.5	1.2	2.2	0.6	1.0	100	21.5	9.2	1,101
Fourth	48.1	16.8	2.5	7.3	0.9	19.1	0.9	2.5	1.3	0.6	100	23.8	8.2	1,126
Highest	52.6	10.9	3.0	9.9	1.5	17.6	1.0	2.2	0.9	0.4	100	21.7	8.6	1,094
Total	**50.0**	**16.3**	**3.6**	**6.7**	**0.9**	**18.1**	**0.9**	**2.1**	**0.9**	**0.5**	**100**	**22**	**8.5**	**5,572**

Note: Table is based on de jure members, i.e., usual residents.

[1] Includes children with father dead, mother dead, both dead, and one parent dead but missing information on survival status of the other parent

Table 5: Household population by age, sex, and residence

Percent distributions of the de facto household population by various age groups and percentage of the de facto household population age 10-19, according to sex and residence, Uganda DHS 2022

	Refuges			Host Community			National		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
Age									
<5	18.4	17.4	17.9	15.7	16.7	16.2	17.2	16.4	16.8
5-9	20.7	17.5	19.0	17.5	17.1	17.3	17.4	16.3	16.9
10-14	19.8	17.8	18.7	16.8	15.4	16.1	15.9	15.0	15.4
15-19	13.6	9.9	11.6	10.9	8.9	9.9	10.0	8.7	9.3
20-24	6.9	6.5	6.7	6.8	7.9	7.3	6.8	8.1	7.5
25-29	3.9	5.3	4.6	6.4	6.3	6.4	6.0	7.0	6.5
30-34	3.3	5.9	4.7	5.3	5.4	5.3	5.0	5.3	5.2
35-39	3.2	5.1	4.2	4.6	4.6	4.6	4.5	4.9	4.7
40-44	2.6	3.3	3.0	3.3	3.4	3.3	3.8	3.7	3.7
45-49	2.0	2.0	2.0	3.4	2.6	3.0	4.4	3.0	3.2
50-54	1.2	3.1	2.2	2.4	3.3	2.9	2.8	3.4	3.1
55-59	1.3	1.7	1.5	1.8	2.3	2.0	2.1	2.1	2.1
60-64	1.1	1.3	1.2	2.2	1.9	2.0	1.9	1.8	1.9
65-69	0.8	1.2	1.0	1.0	1.3	1.1	1.1	1.2	1.2
70-74	0.5	0.8	0.6	1.0	1.1	1.1	0.9	1.1	1.0
75-79	0.3	0.5	0.4	0.5	0.7	0.6	0.5	0.6	0.6
80 +	0.3	0.7	0.5	0.4	1.0	0.7	0.7	1.2	1.0
Don't know/missing	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2
Dependency age groups									
0-14	58.9	52.7	55.6	50.0	49.2	49.6	50.5	47.7	49.1
15-64	39.2	44.2	41.8	47.1	46.5	46.8	46.1	48.0	47.1
65+	2.0	3.1	2.6	2.9	4.1	3.5	3.2	4.1	3.7
Don't know/missing	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.2	0.2
Child and adult populations									
0-17	67.6	59.0	63.0	57.5	54.8	56.2	57.2	53.1	55.1
18+	32.4	41.0	37.0	42.5	45.2	43.8	42.8	46.8	44.8
Don't know/missing	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1
Adolescents 10-19	33.4	27.7	30.4	27.7	24.3	26.0	25.9	23.7	24.8
Number of persons	5,484	6,238	11,722	4,900	5,023	9,924	43,992	46,150	90,142

Table 6: Birth registration of children under age 5

Percentage of host de jure children under age 5 whose births are registered with the civil authorities, according to background characteristics, 2016 & 2022

Characteristic	HOST COMMUNITY				REFUGEES			
	Percentage of children whose births are registered and who:		Total percentage of children whose births are registered	Number of children	Percentage of children whose births are registered and who:		Total percentage of children whose births are registered	Number of children
	Had a birth certificate	Did not have a birth certificate			Had a birth certificate	Did not have a birth certificate		
Age								
<2	4.8	17.1	21.9	599	21.4	26.4	47.8	774
2-4	6.7	16.2	22.9	1,010	20.2	25.9	46.1	1,322
Sex								
Male	5.8	17.3	23.1	769	20.4	26.3	46.7	1,009
Female	6.1	15.9	22.1	840	20.9	25.9	46.8	1,086
Residence								
Urban	8.9	24.2	33.1	674	21.8	26.4	48.2	828
Rural	3.8	11.1	14.9	936	19.9	25.9	45.8	1,267
Wealth quintile								
Lowest	1.4	9.0	10.8	372	14.2	28.5	42.8	485
Second	7.1	16.8	23.9	319	16.6	27.9	44.6	464
Middle	8.8	19.7	28.5	348	24.3	24.2	48.6	404
Fourth	7.0	18.8	25.7	297	25.7	23.4	49.1	389
Highest	6.1	20.3	26.5	273	24.9	25.5	50.4	354
Total	**6.0**	**16.6**	**22.6**	**1,609**	**20.6**	**26.1**	**46.8**	**2,096**

Table 7: Educational attainment among refugees

Percent distribution of the de facto household population age 6 and over by highest level of schooling attended or completed and average years completed, according to background characteristics, Uganda DHS 2022

Age group	No education	Some primary	Completed primary[1]	Some secondary	Completed secondary[2]	More than secondary	Don't know/ missing	Total	Average years completed
					Females				
6-9	56.9	43.1	0.0	0.0	0.0	0.0	0.0	100	1.2
10-14	10.0	89.4	0.1	0.5	0.0	0.0	0.0	100	2.4
15-19	8.6	72.1	8.8	10.1	0.0	0.4	0.0	100	4.8
20-24	18.4	44.5	12.6	21.7	1.5	1.0	0.3	100	5.4
25-29	34.0	38.0	6.0	16.0	2.1	3.4	0.6	100	4.3
30-34	45.6	36.6	4.7	9.7	1.2	2.2	0.0	100	3.2
35-39	47.6	39.6	5.2	6.1	0.7	0.5	0.2	100	2.5
40-44	56.0	33.7	3.7	3.9	1.2	1.0	0.5	100	2.1
45-49	61.3	27.5	4.4	6.2	0.0	0.0	0.6	100	2.0
50-54	60.3	29.0	2.8	5.7	0.6	1.2	0.4	100	2.0
55-59	69.1	22.9	2.1	4.9	0.0	1.0	0.0	100	1.5
60-64	72.6	20.7	2.2	3.0	0.0	0.0	1.5	100	1.0
65+	87.5	11.0	0.4	0.0	0.0	0.6	0.4	100	0.5
Total	**36.1**	**52.8**	**3.7**	**6.1**	**0.5**	**0.7**	**0.2**	**100**	**2.8**

Table 7 *Cont'd*: Educational attainment among refugees

Percent distribution of the de facto household population age 6 and over by highest level of schooling attended or completed and average years completed, according to background characteristics, Uganda DHS 2022

Age group	No education	Some primary	Completed primary[1]	Some secondary	Completed secondary[2]	More than secondary	Don't know/ missing	Total	Average years completed
					Males				
6-9	55.0	44.8	0.1	0.1	0.0	0.0	0.0	100	1.3
10-14	10.2	88.4	0.8	0.6	0.0	0.0	0.0	100	2.4
15-19	5.6	70.1	9.8	14.4	0.0	0.0	0.1	100	5.1
20-24	10.1	35.5	12.9	36.2	**2.7**	2.2	0.3	100	6.7
25-29	20.6	30.9	8.0	23.6	8.4	8.1	0.4	100	6.6
30-34	19.9	29.7	8.8	25.8	9.0	6.9	0.0	100	6.8
35-39	21.3	33.5	3.7	26.0	7.1	6.6	1.8	100	6.3
40-44	25.7	37.6	7.6	20.4	4.6	3.4	0.5	100	5.3
45-49	28.2	45.2	5.1	15.9	3.2	2.4	0.0	100	4.5
50-54	29.9	47.2	4.5	13.9	2.2	1.1	1.1	100	3.9
55-59	28.7	38.8	6.8	13.4	5.7	4.5	2.1	100	4.8
60-64	19.5	51.6	3.9	19.6	3.6	1.8	0.0	100	5.3
65+	56.7	31.3	1.9	6.6	0.0	2.1	1.4	100	2.3
Total	**23.3**	**57.2**	**4.7**	**11.3**	**1.8**	**1.5**	**0.3**	**100**	**3.8**

[1] Completed 7th grade at the primary level [2] Completed 6th grade at the secondary level

Table 7A: Educational attainment of the household population among the host community

Percent distribution of the de facto male household population age 6 and over by highest level of schooling attended or completed and median years completed, according to background characteristics, Uganda DHS 2022

Age group	No education	Some primary	Completed primary[1]	Some secondary	Completed secondary[2]	More than secondary	Don't know/ missing	Total	**Mean years completed**
				Females					
6-9	47.5	52.5	0.0	0.0	0.0	0.0	0.0	100	1.2
10-14	5.9	92.2	0.9	0.9	0.0	0.0	0.1	100	2.7
15-19	5.0	64.7	14.5	15.6	0.2	0.0	0.0	100	5.4
20-24	5.8	47.2	13.7	29.5	0.6	3.3	0.0	100	6.6
25-29	4.9	53.6	14.1	20.5	0.6	6.1	0.2	100	6.6
30-34	7.8	53.5	15.9	15.4	1.5	6.0	0.0	100	6.2
35-39	15.5	47.8	19.7	12.4	0.8	3.2	0.5	100	5.3
40-44	26.5	52.9	11.2	7.9	0.0	1.6	0.0	100	3.9
45-49	32.0	57.0	6.8	2.7	0.0	1.4	0.0	100	3.0
50-54	38.2	48.4	9.5	3.5	0.0	0.4	0.0	100	2.7
55-59	44.6	44.6	3.5	5.9	0.0	1.3	0.0	100	2.8
60-64	52.5	24.7	10.0	9.7	0.0	1.6	1.5	100	2.9
65+	71.3	24.8	2.5	0.6	0.0	0.9	0.0	100	1.2
Total	**22.2**	**58.5**	**8.0**	**9.2**	**0.3**	**1.6**	**0.1**	**100**	3.8

Table 7A: Educational attainment of the household population among the host community

Percent distribution of the de facto male household population age 6 and over by highest level of schooling attended or completed and median years completed, according to background characteristics, Uganda DHS 2022

Age group	No education	Some primary	Completed primary[1]	Some secondary	Completed secondary[2]	More than secondary	Don't know/ missing	Total	**Mean years completed**
				Males					
6-9	49.4	50.5	0.1	0	0	0	0	100	1.0
10-14	7.1	91	1.7	0.2	0	0	0	100	2.6
15-19	4.8	70.2	9.9	13.9	0.1	1	0	100	5.2
20-24	4.3	44	16.2	31	2.3	1.8	0.3	100	6.8
25-29	4.2	38.4	15	26.8	5.2	10.3	0.2	100	7.9
30-34	6.6	35.3	20.6	24.6	2.8	9.4	0.7	100	7.5
35-39	7.1	34.3	18	27.9	5.2	6.4	1.1	100	7.5
40-44	8.7	39.2	19.5	20.2	2.1	9.6	0.8	100	7.1
45-49	10.4	40.2	18.1	20	0.5	10.3	0.5	100	6.7
50-54	13.5	49.3	14.1	15.4	0.7	6	1	100	5.5
55-59	16	44.7	14.2	17	4.4	3.8	0	100	5.7
60-64	12.8	47.7	16.2	19.4	0	3.8	0	100	5.5
65+	23.6	41.4	14	15.6	0.5	3.8	1.1	100	4.9
Total	**15.2**	**56.6**	**9.8**	**13.4**	**1.3**	**3.4**	**0.3**	**100**	**4.7**

Table 8: School attendance ratios

Net attendance ratios (NAR) and Gross Attendance Ratios (GAR) for the de facto household population by sex and level of schooling; and the Gender Parity Index (GPI), according to background characteristics, Uganda DHS 2022

Background characteristic	Refugees				Host Community			
	Net attendance ratio[1]				Net attendance ratio[1]			
	Male	Female	Total	Gender Parity Index[2]	Male	Female	Total	Gender Parity Index[2]
PRIMARY SCHOOL								
Wealth quintile								
Lowest	56.5	54.7	55.6	1.0	72.6	72.4	72.5	1.0
Second	54.8	55.5	55.1	1.0	69.1	75.1	72	1.1
Middle	64.7	66	65.3	1.0	69.4	66.8	68	1.0
Fourth	71.9	74.2	73	1.0	72.8	74	73.4	1.0
Highest	71.5	68.4	70	1.0	75.3	79.1	77.2	1.1
Total	**63.9**	**63.8**	**63.9**	**1.0**	**71.9**	**73.4**	**72.6**	**1.0**
SECONDARY SCHOOL								
Wealth quintile								
Lowest	3.1	0	1.5	0.0	1.1	3	2	2.7
Second	3.9	0.7	2.3	0.2	8.7	5.8	7.3	0.7
Middle	6.7	4.4	5.6	0.7	7.2	14	10.2	1.9
Fourth	7.3	7.6	7.4	1.0	10.4	4.9	7.9	0.5
Highest	12.7	7.8	10.5	0.6	12.8	22.3	17.1	1.7
Total	**7.2**	**4.4**	**5.9**	**0.6**	**8.4**	**10.2**	**9.2**	**1.2**

[1] The NAR for primary school is the percentage of the primary-school age (6-12 years) population that is attending primary school. The NAR for secondary school is the percentage of the secondary-school age (13-18 years) population that is attending secondary school. By definition the NAR cannot exceed 100 percent.

[2] The Gender Parity Index for primary school is the ratio of the primary school NAR (GAR) for females to the NAR (GAR) for males. The Gender Parity Index for secondary school is the ratio of the secondary school NAR (GAR) for females to the NAR (GAR) for males.

Table 9: Disability by domain and age

Percent distribution of de facto household population age 5 and over by the degree of difficulty in functioning according to domain, and percent distribution by the highest degree of difficulty in functioning in at least one domain by age, Uganda DHS 2022

Domain and age	Degree of difficulty					Total	A lot of difficulty or cannot do at all
	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all	Don't know/ missing		
Domain				**Refugees**			
Difficulty seeing	91.2	7	1.6	0.1	0	100	1.7
Difficulty hearing	94.6	4.5	0.8	0.2	0	100	1.0
Difficulty communicating	98.4	1	0.3	0.2	0	100	0.5
Difficulty remembering or concentrating	94.3	4.1	1.2	0.3	0.1	100	1.5
Difficulty walking or climbing steps	93.7	4.5	1.5	0.3	0	100	1.8
Difficulty washing all over or dressing	96.4	1.9	0.7	1	0	100	1.7
Difficulty in at least one domain[1]							
5-9	87.3	7.5	2.8	2.4	0.0	100	5.4
10-14	90.2	7.2	2.0	0.5	0.0	100	3.5
15-19	89.8	7.7	2.1	0.4	0.0	100	2.9
20-29	88.1	9.2	2.2	0.4	0.0	100	3.1
30-39	84.2	12.8	2.6	0.4	0.0	100	5.0
40-49	71.0	23.3	5.4	0.4	0.0	100	7.4
50-59	54.1	35.7	9.6	0.6	0.0	100	11.0
60+	32.6	38.9	24.6	3.9	0.0	100	27.8
Age 15 and over	75.5	17.7	5.7	1	0	100	6.7
Total	**80.8**	**13.6**	**4.6**	**1.1**	**0.0**	**100**	**5.7**

Table 9: Disability by domain and age

Percent distribution of de facto household population age 5 and over by the degree of difficulty in functioning according to domain, and percent distribution by the highest degree of difficulty in functioning in at least one domain by age, Uganda DHS 2022

Domain and age	Degree of difficulty					Total	A lot of difficulty or cannot do at all
	No difficulty	Some difficulty	A lot of difficulty	Cannot do at all	Don't know/ missing		
Domain	**Host Community**						
Difficulty seeing	93	6.1	0.8	0	0	100	0.8
Difficulty hearing	96.6	2.9	0.3	0.2	0	100	0.5
Difficulty communicating	98.9	0.6	0.2	0.2	0	100	0.4
Difficulty remembering or concentrating	96.8	2.4	0.7	0.1	0	100	0.8
Difficulty walking or climbing steps	95.4	3.5	0.8	0.3	0	100	1.1
Difficulty washing all over or dressing	97.9	1.2	0.5	0.4	0	100	0.9
Difficulty in at least one domain[1]							
5-9	91.6	4.9	1.9	1.6	0.0	100	5.4
10-14	92.8	5.5	1.5	0.1	0.0	100	3.5
15-19	93.1	5.1	1.4	0.5	0.0	100	2.9
20-29	91.9	6.1	1.5	0.6	0.0	100	3.1
30-39	90.1	8.5	1.4	0.1	0.0	100	5.0
40-49	78.8	17.7	3	0.4	0.0	100	7.4
50-59	64.3	31.3	3.2	1.1	0.0	100	11.0
60+	47.1	40.2	10	2.8	0.0	100	27.8
Age 15 and over	82.4	14.1	2.7	0.8	0	100	3.5
Total	86.3	10.5	2.3	0.8	0.0	100	3.1

[1] If a person was reported to have difficulty in more than one domain, only the highest level of difficulty is shown.

Table 10: Sources for Household drinking water

Percent distribution of households and de jure population by source of drinking water, time to obtain drinking water, and treatment of drinking water, according to residence, Uganda DHS 2022

Characteristic	Refugees	Host	National
Source of drinking water			
Improved source	**84.9**	**77.1**	**81.7**
Piped into dwelling/yard/plot	1.1	3.5	6.9
Piped to neighbour	5.4	6.9	8.3
Public tap/standpipe	40.8	7.6	7.8
Tube well or borehole	34.5	46.4	41.6
Protected well	0.7	5.2	6.3
Protected spring	2.1	4.7	7.9
Other (Rain Water/ Bottled Water/Sachet)	0.3	2.8	1.9
Unimproved source	**14.6**	**22.5**	18.3
Unprotected well	5.1	11.4	8
Unprotected spring	1.2	1.7	2.9
Tanker truck	0.3	0.3	0.4
Bicycle with jerry can	0.2	0.2	0.2
Surface water	8.0	8.9	6.8
Other	**0.4**	**0.5**	0.0
Time to obtain drinking water (round trip)			
Water on premises[2]	16.1	17.6	20
Less than 30 minutes	62.0	50.1	54.3
30 minutes or longer	21.9	32.1	25.5
Don't know	0.1	0.1	0.2
Total	**100**	**100**	**100**
Water treatment prior to drinking[3]			
Boil	17.7	24.2	42.5
Bleach/chlorine added	1.7	0.9	1.6
Strain through cloth	0.5	1.4	1.4
Ceramic, sand or other filter	1.7	0.2	0.4
Solar disinfection	0.3	-	0.1
Let it stand and settle	1.0	0.4	0.7
Other			
No treatment	78.0	74.3	54.6
Percentage using an appropriate treatment	**21.0**	**25.2**	44.1
Number of households	**2,276**	**2,163**	**19,758**

[1] Because the quality of bottled water is not known, households using bottled water for drinking are classified as using an improved or unimproved source according to their water source for cooking and handwashing.

[2] Includes water piped to a neighbor

[3] Respondents may report multiple treatment methods so the sum of treatment may exceed 100 percent.

[4] Appropriate water treatment methods include boiling, bleaching, filtering and solar disinfecting.

Table 11: Drinking water service ladder

Percent distribution of de jure population by drinking water service ladder

	Basic	Limited	Unimproved	Surface	Total	Number
			Refugees			
Wealth quintile						
Lowest	42.6	19.8	15.1	22.6	100	2,356
Second	70.3	17.6	5.9	6.2	100	2,364
Middle	74.8	18.1	4.2	2.9	100	2,345
Fourth	81.5	13.9	2.2	2.4	100	2,360
Highest	74.7	18.5	3.5	3.3	100	2,348
Total	**68.8**	**17.6**	**6.2**	**7.5**	**100**	**11,773**
			Host Community			
Wealth quintile						
Lowest	50.3	36.5	5.8	7.4	100	2,009
Second	49.3	27.9	9.4	13.3	100	2,011
Middle	49.1	26.4	13.2	11.3	100	2,005
Fourth	46.7	22.4	21.0	9.8	100	2,004
Highest	61.5	18.0	15.6	4.9	100	2,005
Total	**51.4**	**26.3**	**13.0**	**9.4**	**100**	**10,034**
			National			
Residence						
Urban	76.2	12.2	8.5	1.2	100	25,792
Rural	55.1	23.5	12.7	8.7	100	64,349
Wealth quintile						
Lowest	53.9	26.5	10.6	9	100	18,033
Second	50.3	26	13.8	9.9	100	18,030
Middle	53.5	22.8	15.1	8.5	100	18,023
Fourth	62.2	19.7	12.2	5.9	100	18,027
Highest	85.7	6.1	5.7	2.4	100	18,028
Total	61.1	20.5	11.5	7.1	**100**	90,142

Note: Service ladder concept/definitions are based on the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation, and Hygiene (JMP).

1 Defined as drinking water from an improved source, provided either water is on the premises or round-trip collection time is 30 minutes or less. Includes safely managed drinking water, which is not shown separately

2 Drinking water from an improved source, and round-trip collection time is more than 30 minutes or is unknown

3 Drinking water from an unprotected dug well or unprotected spring

Table 12: Household sanitation facilities

Percent distribution of households and de jure population by type of toilet/latrine facilities and percent distribution of households and de jure population with a toilet/latrine facility by location of the facility, according to residence, Uganda DHS 2022

Type and location of toilet/latrine facility	Refugees	Host Community	National		
			Urban	Rural	Total
Improved sanitation	**29.1**	**27.8**	**33.0**	**39.9**	**30.9**
Flush to piped sewer systems	-	-	**1.2**	**0.0**	**0.4**
Flush to septic tank	-	0.3	4.2	0.2	1.5
Flush to pit latrine	0.3	0.2	0.4	0.1	0.2
Ventilated improved pit latrine	2.2	3.7	8.4	5.2	6.3
Pit latrine with slab	26.3	23.3	18.7	23.5	22.0
Composting toilet	0.3	0.3	0.1	0.8	0.6
Unimproved sanitation					
Shared facility[1]	**15.5**	**19.5**	42.3	15.8	24.3
Flush to piped sewer systems	-	-	0.5	0.0	0.2
Flush to septic tank	-	0.0	1.8	0.0	0.6
Flush to pit latrine	0.1	0.2	1.6	0.1	0.6
Ventilated improved pit latrine	1.8	2.6	13.1	3.1	6.3
Pit latrine with slab	13.4	16.5	25.2	12.4	16.5
Composting toilet	0.2	0.2	0.1	0.1	0.1
Unimproved facility	**48.4**	**51.0**	**23.1**	**46.4**	**38.9**
Flush to somewhere else	0.2	0.0	0.3	0.1	0.2
Pit latrine without slab/open pit	46.7	49.9	22.3	44.7	37.5
Bucket toilet	0.2		0.0	0.0	0.0
Hanging toilet	1.3	1.1	0.6	1.5	1.2
Open defecation (no facility/bush/field)	**7.0**	**1.6**	**1.7**	**7.9**	**5.9**
Total	100	100	100	100	100
Number of households	2,276	2,163	6,323	13,435	19,758
Location of the facility					
In own dwelling	2.1	1.1	6.9	1.7	3.5
In own yard/plot	76.3	82.2	82	84.7	83.5
Elsewhere	21.6	16.6	11.1	13.6	12.7
Total	100	100	100	100	100
Number of households with a toilet/latrine facility	**2,117**	**2,129**	**6,219**	**12,380**	**18,599**

[1] Facilities that would be considered improved if they were not shared by two or more households

Table 13: Sanitation service ladder

Percent distribution of de jure population by type of sanitation service, by background characteristics

	At least	Limited	Unimproved[3]	Open	Total	Number
			Refugees			
Wealth quintile						
Lowest	33.4	11.7	43.1	11.8	100	2,337
Second	26.4	16.2	45.2	12.2	100	2,351
Middle	26.9	16.9	52.0	4.2	100	2,342
Fourth	24.0	16.1	55.8	4.1	100	2,360
Highest	42.2	8.3	47.9	1.6	100	2,348
Total	**30.6**	**13.8**	**48.8**	**6.8**	**100**	**11,738**
			Host Community			
Lowest	1.8	2.6	92	3.5	100	2,009
Second	16.2	16.9	65.4	1.5	100	2,011
Middle	35.3	15.8	47.7	1.2	100	2,005
Fourth	43.4	19.4	37	0.1	100	2,004
Highest	62.5	23.3	14.2	0.1	100	2,005
Total	**31.8**	**15.6**	**51.3**	**1.3**	**100**	**10,034**

Note: Service ladder concept/definitions are based on the WHO/UNICEF Joint Monitoring Programme for Water Supply, Sanitation, and Hygiene (JMP).

1 Defined as use of improved facilities that are not shared with other households. Includes safely managed sanitation service,which is not shown separately.

2 Defined as use of improved facilities shared by two or more households

3 Use of flush/pour flush toilet not to sewer, septic tank, or pit latrine; pit latrine without a slab/open pit; or bucket

Table 14: Hand washing

Percentage of households in which the place most often used for washing hands was observed by whether the location was fixed or mobile and total percentage of households in which the place for hand washing was observed; and among households in which the place for hand washing was observed, percent distribution by availability of water, soap and other cleansing agents, according to background characteristics Uganda DHS 2022

Background characteristic	Percentage of households in which place for washing hands was observed:			Number of households	Among households in which place for hand washing was observed, percentage with:							Number of households in which place for hand washing was observed
	And place for handwashing was a fixed place	And place for handwashing was mobile	Total		Soap and water[1]	Water and cleansing agent other than soap only[2]	Water only	Soap but no water[3]	Cleansing agent other than soap only[2]	No water, no soap, no other cleansing agent	Total	
Refugees	6.9	28.1	35.0	2,276	34.6	1.6	28.6	1.2	0.4	33.6	100	796
Host Community	8.2	37.1	45.3	2,163	40.1	1.1	27	1.7	0.9	29.2	100	981
National	12.2	38.1	50.8	20	43.3	0.6	21.2	1.7	0.3	32.9	100	10,038
Residence												
Urban	16	43.9	59.8	6,323	55.2	0.2	18.5	1.7	0.1	24.3	100	3,784
Rural	11.2	35.4	46.6	13,435	36.1	0.8	22.9	1.8	0.3	38.1	100	6,255

[1] Soap includes soap or detergent in bar, liquid, powder or paste form. This column includes households with soap and water only, as well as those that had soap and water and another cleansing agent.

[2] Cleansing agents other than soap include locally available materials such as ash, mud or sand.

[3] Includes households with soap only, as well as those with soap and another cleansing agent

Table 15: Age at first marriage

Percent of women age 15-49 years who were married by specific exact ages, according to current age Uganda DHS 2022

Current Age	Percentage first married by exact age									
	15		18		20		22		25	
	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda
15-19	0.8	2.6	12.6	30.0	na	na	na	na	na	na
20-24	3.2	5.8	30.8	32.8	52.0	55.8	68.4	74.2	na	na
25-29	8.4	10.1	37.8	35.3	58.5	54.1	70.9	70.9	82.7	85.5
30-34	12.8	13.5	39.5	39.8	56.2	57.3	67.9	70.9	79.0	84.3
35-39	9.6	13.9	32.4	44.1	49.5	61.5	64.9	72.7	79.8	84.3
40-44	10.0	15.8	29.4	47.7	51.5	66.3	65.3	77.6	78.5	85.3
45-49	7.4	14.9	27.8	47.6	36.9	66.3	52.6	76.9	77.2	86.2

Table 16: Teenage pregnancy and motherhood among refugees

Percentage of women age 15-19 who have had a live birth or who are pregnant with their first child, and percentage who have begun childbearing, according to background characteristics, Uganda DHS 2022

Background characteristic	Have had a live birth	Age pregnant with first child	Percentage who have begun childbearing	Have had a live birth	Age pregnant with first child	Percentage who have begun childbearing
	Refugees			National		
Age						
15	0.7	0.7	1.3	6.7	3.4	10
16	2.1	1.9	3.9	2.7	0.6	3.3
17	11.4	0.6	12	5.1	3.4	8.5
18	15.3	3.2	18.5	13.4	6.7	20.1
19	28.4	1.3	29.7	29.5	7.3	36.8
20	68.1	0	68.1	46.9	8.6	56.5
Sub Region						
Acholi	14	2.3	16.3	15.2	6.4	21.7
Ankole	11.9	0	11.9	12	5.2	17.2
Bunyoro	13	2	15	18.3	5.8	24.2
Tooro	11	3.3	14.3	21.3	5.4	26.7
West Nile	10.5	0.9	11.4	14.6	6.4	18.2
Education						
No education	21.5	3.1	24.7	20.5	6.6	27.1
Primary	10.7	1.6	12.2	20.7	5.8	26.5
Secondary	11.7	0	11.7	13.8	3.6	17.4
More than secondary	0	0	0	5.1	2.4	7.6
Wealth Quintile						
Lowest	15.9	5.1	21	27.7	5.5	33.3
Second	14.5	0.7	15.2	22.7	5.1	27.9
Middle	10.5	1.3	11.8	17.7	6.1	23.8
Fourth	10.9	0.7	11.5	14.8	5.8	20.6
Highest	7.4	0.6	8	12.1	3.3	15.3
Total	**11.5**	**1.5**	**13**	**18.2**	**5.1**	**25.3**

Table 17: Fertility planning status

Percent distribution of births to women age 15-49 in the 5 years preceding the survey (including current pregnancies), by planning status of the birth, according to birth order, Uganda DHS 2022

Birth order	Planning status of birth		
	Wanted then	Wanted later	Wanted no more
	Refugees		
1	71.5	28.5	0
2	71.5	28.5	0
3	68.8	31.2	0
4+	68.6	31	0.4
Total	**69.5**	**30.3**	**0.2**
	Host Community		
1	75.7	22.3	2
2	71.6	27.9	0.5
3	79.4	19	1.6
4+	72.7	18	9.2
Total	**74.2**	**21.1**	**4.7**
	National		
1	64.8	33.5	1.7
2	71.5	27.4	1.1
3	71.5	27.1	1.4
4+	62.7	25.4	12
Total	**66.2**	**27.7**	**6**

Table 18: Fertility preferences according to number of living children

Percent distribution of currently married women and currently married men age 15-49 by desire for children, according to number of living children, Uganda DHS 2022

Desire for children	Number of living children							Total 15-59
	0	1	2	3	4	5	6+	
	Refugees							
Have another soon2	38.9	9.8	17.7	21.9	15.9	12.8	7.3	13.8
Have another later3	61.1	77.7	45.6	39.4	38	23.2	12.7	33.6
Have another, undecided when	0	4.3	10.8	10.9	16.4	4.2	6.6	8.8
Undecided	0	0	4.6	2.5	3.3	10.4	1.7	3.6
Want no more	0	6	18.4	25.3	25.4	48.5	66.2	37.7
Sterilised	0	0	0	0	0	0	1.9	0.6
Declared infecund	0	2.2	2.9	0	0.9	1	3.6	1.9
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
	National							
Have another soon2	71.9	22.9	17.4	15.4	11.3	8.7	3.6	14.5
Have another later3	13.4	66.9	62.7	56.5	36.3	25.3	9.7	40.3
Have another, undecided when	1.4	0.9	0.9	0.8	0.7	1	0.2	0.7
Undecided	4	4.8	6.9	5.6	9	9	7.2	6.9
Want no more	1.2	3.1	10.2	19	37.8	48.8	68.2	32.2
Sterilised4	0.9	0.1	0.7	1	2.5	5	6.5	2.8
Declared infecund	7.1	1.3	1.2	1.7	2.3	2.3	4.9	2.6
Total	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**

1 The number of living children includes the current pregnancy.

2 Wants next birth within 2 years

3 Wants to delay next birth for 2 or more years

Table 19: High-risk fertility behaviour

Percent distribution of children born in the 5 years preceding the survey by category of elevated risk of mortality, and percent distribution of currently married women by category of risk if they were to conceive a child at the time of the survey, Uganda DHS 2022

Risk category	Percentage of Births in the 5 years preceding the survey	
	Refugees	National
Not in any high-risk category	29.1	23.9
Unavoidable risk category		
First-order births between ages 18 and 34	11.8	15.3
In any avoidable high-risk category	59.2	60.9
Single high-risk category		
Mother's age <18 only	7.2	5.3
Mother's age >34 only	0.4	0.5
Birth interval <24 months only	1.0	8.9
Birth order >3 only		22.8
Subtotal	8.6	37.5
Subtotals by individual avoidable high-risk		
Mother's age <18	7.5	5.9
Mother's age >34	13.4	14.3
Birth interval <24 months	2.2	21.6
Birth order >3	50.6	45.4

Table 20: Person providing assistance during ANC (%)

Characteristic	Antenatal care provider							
	Doctor		Nurse/midwife		Medical assistant/ nursing aide		No ANC	
	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda
Residence								
Urban	5.9	17.1	88.5	80.2	1.9	1.4	3.7	1.3
Rural	5.1	5.5	89.6	91.1	1.4	1.9	4	1.2
Region								
West Nile	**5.9**	**6.9**	**88.5**	**91.2**	**1.9**	**0.5**	**3.7**	**1.4**
South West	**5.1**	**5.6**	**89.6**	**93.2**	**1.4**	**0.1**	**4**	**1**
Highest educational level								
No education	4.1	2.2	88.1	93.7	1.5	0.2	6.3	3.7
Primary	6	6.6	89.8	90.4	1.4	1.7	2.8	1.2
Secondary	8.7	14.4	89.2	82.1	1.1	2.6	1.1	0.7
Higher	0	16	92.8	82.4	7.2	0.5	0	0.8
Wealth index quintile								
Lowest	2.8	2.6	90.8	94.6	2.1	1.1	4.3	1.6
Second	5.4	4.1	89.6	91,7	1.2	2.6	3.7	1.5
Middle	8.1	5.7	87.1	90.1	1.6	2.4	3.2	1.4
Fourth	7.7	10.7	86.1	85.8	2.6	2	3.6	1.2
Highest	3.5	22	91.9	76.5	0	0.8	4.6	0.9
Total	**5.4**	**8.9**	**89.2**	**87.9**	**1.6**	**1.8**	**3.9**	**1.3**

Table 21a: Early childhood mortality rates

Neonatal, post neonatal, infant, child, and under-5 mortality rates for five-year periods preceding the survey, Uganda DHS 2022

Years preceding the survey	Neonatal mortality (NN)			Post neonatal mortality (PNN)[1]			Infant mortality ($_1q_0$)			Child mortality ($_4q_1$)			Under-5 mortality ($_5q_0$)		
	Refugees	Host	All Uganda	Refugees	Host	All Uganda	Refugees	Host	All Uganda	Refugees	Host	All Uganda	Refugees	Host	All Uganda
0-4	12.2	23.7	22.0	11.2	9.6	14.0	23.5	33.3	36.0	22.4	12.6	17.0	45.4	45.5	52
5-9	19.1	23.4	23.0	15.5	18.5	14.0	34.6	41.8	36.0	26.6	17.3	19.0	60.2	58.4	54
10-14	18.0	30.1	27.0	21.1	32.6	21.0	39.1	62.7	49.0	29.0	38.9	28.0	67.0	99.2	75

[1] Computed as the difference between the infant and neonatal mortality rates

Table 21b: Early childhood mortality rates according to socio-economic characteristics

Neonatal, post neonatal, infant, child, and under-5 mortality rates for five-year periods preceding the survey, Uganda DHS 2022

	Neonatal mortality (NN)		Post neonatal mortality (PNN)[1]		Infant mortality ($_1q_0$)		Child mortality ($_4q_1$)		Under-5 mortality ($_5q_0$)	
	Refugees	All	Refugees	All	Refugees	All	Refugees	All	Refugees	All
Residence										
Urban	15.7		7.4		23.1		17.8		40.5	
Rural	10.0		13.6		23.7		25.6		48.6	
Refugee Regions										
West Nile	17.4		9.4		26.8		21.7		48.0	
South West	14.3		15.9		30.1		26.1		55.4	
Birth Order										
1	20.6	16.0	15.4	12.0	36.0	27.0	17.5	13.0	52.9	40.0
2-3	14.6	25.0	14.1	15.0	28.7	40.0	30.8	18.0	58.5	57.0
4-6	14.2	40.0	9.3	19.0	23.5	59.0	17.4	22.0	40.5	80.0
7+	15.4	36.0	19.2	115.0	34.6	150.0	36.9	21.0	70.3	168.0
Birth size										
Small/very small	6.3	35.0	14.4	20.0	20.7	55.0	na	na	na	na
Average or larger	9.9	30.0	9.7	14.0	19.6	44.0	na	na	na	na
Mother's age at										
<20	18.0	30.0	17.9	16.0	35.9	46.0	25.6	18.0	60.6	63.0
20-29	16.7	20.0	12.3	12.0	29.0	32.0	24.3	16.0	52.6	47.0
30-39	13.0	21.0	11.8	14.0	24.9	35.0	19.2	19.0	43.6	54.0
40-49	10.0	33.0	27.7	35.0	37.7	67.0	103.9	31.0	137.7	96.0
Wealth quintile										
Poorest	20.5	19.0	22.7	17.0	43.2	36.0	32.9	24.0	74.7	59.0
Poorer	14.6	23.0	17.0	13.0	31.6	36.0	37.9	16.0	68.3	52.0
Middle	18.2	25.0	7.2	14.0	25.5	39.0	16.0	19.0	41.1	57.0
Richer	15.6	25.0	9.4	14.0	25.0	40.0	20.3	14.0	44.8	53.0
Richest	6.9	21.0	7.4	11.0	14.3	32.0	12.1	12.0	26.2	44.0

[1] Computed as the difference between the infant and neonatal mortality rates

Table 22: Number of antenatal care visits

	None		1		2-3		4+		Don't know/ missing	
	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda
Residence										
Urban	3.6	1.1	0.3	0.7	12.3	21.1	80	68.4	3.8	8.6
Rural	3.9	1.2	0.7	1.1	19.4	23.4	73.7	67.6	2.3	6.7
Refugee Region										
West Nile	3.6	N/A	0.3	N/A	12.3	N/A	80	N/A	3.8	N/A
South West	3.9	N/A	0.7	N/A	19.4	N/A	73.7	N/A	2.3	N/A
Total	**3.8**	**1.2**	**0.5**	**1.0**	**16.6**	**22.7**	**76.2**	**67.8**	**2.9**	**7.3**

Table 23: Number of months pregnant at time of first ANC visit

Characteristic	No ANC	<4	4-5	6-7	8+	don't know/ missing	No ANC	<4	4-5	6-7	8+	don't know/ missing	No ANC	<4	5-Apr	7-Jun	8+	don't know/ missing
Residence	**HOST COMMUNITY**						**REFUGEE**						**NATIONAL**					
Urban	4.3	50.6	38.8	4.4	1.5	0.3	6.9	65.6	22.8	4.4	0.0	0.3	1.1	39.9	42.9	15.0	1.2	0.0
Rural	1.4	41.9	41.7	14.1	0.9	0.0	5.6	49.9	37.6	5.9	0.7	0.3	1.1	40.3	43.7	14.0	0.8	0.1
Highest educational level																		
No education	5.8	36.1	39.2	18.9	0.0	0.0	9.2	49.3	34.2	6.7	0.4	0.3	3.2	41.0	44.3	10.7	0.7	0.1
Primary	2.6	45.4	41.0	9.8	1.0	0.2	4.8	62.4	27.9	4.5	0.0	0.3	1.1	39.8	43.3	14.7	1.0	0.1
Secondary	0.9	52.0	38.0	6.7	2.3	0.0	1.8	55.6	36.0	4.0	2.5	0.0	0.6	39.8	43.4	15.5	0.7	0.0
Higher	6.9	36.1	49.1	8.0	0.0	0.0	0.0	17.6	82.4	0.0	0.0	0.0	0.8	46.1	42.9	8.7	1.6	0.0
Wealth quintile																		
Lowest	1.0	43.3	42.2	12.1	1.3	0.0	6.7	48.7	36.4	8.2	0.0	0.0	1.3	43.5	42.8	11.4	1.0	0.1
Second	3.4	53.2	35.4	6.2	1.1	0.7	7.0	64.4	26.2	2.4	0.0	0.0	1.4	43.5	40.9	13.8	0.5	0.0
Middle	4.7	43.1	40.9	10.4	0.9	0.0	5.4	57.4	33.2	3.5	0.0	0.5	1.3	34.5	47.4	15.9	1.0	0.0
Fourth	3.7	42.1	42.1	9.6	2.5	0.0	5.8	52.0	33.3	6.4	1.6	1.0	1.1	40.0	42.9	15.0	0.9	0.1
Highest	0.7	47.2	41.3	10.8	0.0	0.0	5.2	59.2	28.8	5.9	0.9	0.0	0.5	38.5	43.8	16.0	1.3	0.0
Total	**2.6**	**45.6**	**40.5**	**10.0**	**1.2**	**0.1**	**6.1**	**56.2**	**31.7**	**5.3**	**0.4**	**0.3**	**1.1**	**40.2**	**43.4**	**14.3**	**0.9**	**0.0**

Table 24: Place of delivery and provider

Percent distribution of live births in the 2 years preceding the survey by place of delivery and percentage delivered in a health facility, according to background characteristics, Uganda DHS 2022

Background characteristic	Health facility					Percentage delivered in a health facility	Percentage delivered by a skilled provider
	Public sector	Private sector	Home	Other	Total		
				Refugees			
Mother's education							
No education	94.4	1	3	1.6	100	95.4	97.4
Primary	96.9	0	2.5	0.6	100	96.9	98.3
Secondary	97.6	0	1	1.4	100	97.6	96.6
More than secondary	92.8	0	0	7.2	100	92.8	100
Total	**95.9**	**0.4**	**2.5**	**1.2**	**100**	**96.3**	**97.8**
				Host Community			
Mother's education							
No education	81.8	0	15.5	2.7	100	81.8	55
Primary	81.9	5.5	11.5	1.1	100	87.4	436
Secondary	83.3	8.1	8.6	0	100	91.4	120
More than secondary	*	*	*	*	*	*	17
Total	**82.3**	**5.7**	**11**	**1.0**	**100**	**88**	
				National			
Mother's education							
No education	70.8	6.2	21.7	1.3	100	77	81.4
Primary	74.1	9.6	15.4	0.8	100	83.7	85.7
Secondary	74.4	18.4	6.6	0.6	100	92.8	94.4
More than secondary	71.8	24.2	4	0	100	96	97.5
Total	**73.8**	**12.5**	**12.9**	**0.8**	**100**	**86.4**	**88.4**

Table 25: Prevalence and treatment of fever

Among children under age 5, the percentage who had a fever in the 2 weeks preceding the survey, and among children with a fever in the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, and percentage who received antibiotics as treatment, according to background characteristics, Uganda DHS 2022

Background characteristic	Among Children under 5		Among children under age 5 with fever:					
	Percentage with fever		treatment was sought1		was sought same or next day		took antibiotic drugs	
	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda	Refugees	All Uganda
Age in months								
<6	10.3	12.7	78.8	80.8	38.7	56.8	41.4	23.4
6-11	21.0	25.1	87.5	83	56.5	48.6	9.9	12.1
12-23	23.6	28.0	89.7	84.3	58.5	48	6.8	11.8
24-35	18.4	26.4	91.7	87.2	56	52.4	8.4	9.7
36-47	17.3	23.6	83.6	86.7	47.8	52.7	8.7	7.2
48-59	14.8	19.1	80.2	88.9	54.5	53.9	6.8	6.3
Sex								
Male	17.5	24.1	85.4	85.5	57.4	51.6	8	9.6
Female	18.7	22.8	87.4	81.9	51.1	51.1	10.9	10.8
Refugee Hosting Sub Regions								
Acholi	43.4	52.0	88.7	92.6	59.7	71.6	9.7	8.7
Ankole	15.9	10.2	81.6	79.3	55.3	51.4	10.5	20.7
Bunyoro	20.6	16.6	90.2	82.2	57.4	42.9	9.8	18.3
Tooro	19.2	16.5	92.8	84.6	55.4	35.3	8.4	7.4
West Nile	12.6	37.0	77.5	88.1	45.1	67.2	9.8	2.5
Total	**18.1**	**23.4**	**86.5**	**85.8**	**54**	**51.4**	**9.5**	**10.2**

Table 26: Prevalence and treatment of diarrhea

Percentage of children under 5 years who had a diarrhea in the 2 weeks preceding the survey, and among children with diarrhea in the 2 weeks preceding the survey, percentage for whom advice or treatment was sought, according to background characteristics, Uganda DHS 2022

Background characteristic	Percentage with diarrhoea		Percentage for whom advice or treatment was sought	
	Refugees	All Uganda	Refugees	All Uganda
Age in months				
<6	8.9	16.2	66	51.6
6-11	15.6	32	78.7	65.9
12-23	19.1	30	86.8	71
24-35	10	18	77.5	71.9
36-47	6.1	11.8	67.3	77.5
48-59	4.7	9.1	80.3	73.4
Sex				
Male	11.6	20.4	78.8	67.2
Female	9.5	18.5	80.4	71
Region				
Acholi	22.4	22.2	90.6	91.6
Ankole	7.5	16.5	88.9	39
Bunyoro	10.8	17.4	84.4	67.8
Tooro	13.9	22.9	83.3	65.1
West Nile	7.4	16.3	60	77.4
Mother's education				
No education	11.2	18.6	76.1	68.3
Primary	9.3	19.7	80.8	68.7
Secondary	15.2	18.9	86	72.5
Higher	0	17.7	79.6	62.4
Wealth quintile				
Lowest	12.4	21	84.7	73.2
Second	11.7	19.7	80.2	71.1
Middle	9	17.9	71.2	68.1
Fourth	10.1	19.8	77.4	65.4
Highest	8.8	17.8	80.7	67
Total	**10.5**	**19.3**	**79.6**	**69.4**

Table 27: Feeding practices during diarrhoea

Percent distribution of children under age 5 who had diarrhoea in the 2 weeks preceding the survey by amount of liquids and food offered compared with normal practice, according to background characteristics, Uganda DHS 2022

	Amount of liquids given for child with diarrhea								Amount of food given to child with diarrhea											
Background	More		Same As usual		Somewhat less		None		More		Same As usual		Some What less		Much less		None		Never gave food	
characteristic	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National
Age in months																				
<6	41.3	12.8	23	39	10.7	22.4	24.9	15.4	46.3	6.5	7.3	24.1	10.7	15.3	35.7	11.4	0	1.8	0	41
6-11	18.5	19.5	42.6	34.7	12.4	25.3	26.5	17.3	16.1	11.8	38.7	32.9	14.9	25.5	10.8	17.4	8.1	3.8	11.4	8.6
12-23	34.3	16.9	26	34.2	17	27.7	22.7	17.8	41.9	11.8	23.9	34.2	19.8	30.5	0	19.5	11.9	1.5	2.6	2.4
24-35	32.4	23.5	27.1	32.4	17.9	24.8	22.7	17.2	44.7	10.9	29.5	38	10	28.9	0	19	15.7	1.9	0	0.7
36-47	42.3	17.3	24.4	34.7	22.7	25.8	6.1	18.4	44.4	9.2	30.8	36.8	20.5	32.2	0	22.4	4.4	1.2	0	0.5
48-59	28.2	14.3	29.8	35.5	26.9	24.6	15.2	19.5	39.1	10	29.8	39.7	11.1	25.4	4.2	18.5	4.2	1.3	11.5	0.5
Sex																				
Male	33.5	17.9	24.3	32.6	19.5	26	21.7	18.6	40.4	11.7	25.5	33.9	17	27	2.8	18.4	12.1	1.7	2.2	7
Female	31.6	18.7	33.4	36.5	15.4	25.5	19.5	16.2	37.3	9.7	29.1	34.9	14.9	28.2	6.7	18.5	6.5	2.2	5.5	6.1
Mother's education																				
No education	32.1	13	23.1	32.9	18.7	34	24.9	19.5	37.2	11	22.5	35.5	18.3	31.2	4.9	20.2	15.6	1.2	1.5	0.8
Primary	31.6	18	35.6	35.4	16.3	23.6	16.4	17.9	38.4	10.4	30.3	34.5	15.4	25.3	5	19.6	3.5	2.2	7.4	7.7
Secondary	36.6	19	24.4	33.4	18.3	27.4	20.8	17.3	45.4	11.3	31.9	34	11.2	31.4	2.6	15.6	8.8	1.7	0	5.4
Higher	32.6	25.9	28.6	32.1	17.6	27.4	20.7	9.8	39	9.4	27.2	35.3	16	29.5	4.6	16.5	9.5	2.2	3.8	7.1
Wealth quintile																				
Lowest	26.1	14	37.9	34.9	15.2	31.5	20.8	14.7	37.4	6.8	33.2	35.1	15.2	30.8	2.4	18.8	4.7	2.1	7.1	6.1
Second	45.4	16.3	19.7	33.3	9.9	24.8	25.0	20.0	40.7	10.1	26.1	35.9	14.6	27.9	3.8	18.1	13.3	1.5	1.6	6.2
Middle	30.1	18.2	25.7	38.4	25.7	20.5	18.4	19.2	43.2	9.1	33.6	34.6	12.7	26	4	20.1	3.3	2.1	3.3	8.2
Fourth	32.5	21.4	29.8	31.4	16	24.1	18.7	19.9	37.6	16.8	22.6	30.1	12.8	23.9	10.3	20.7	14.6	2.3	2.1	5.8
Highest	26.8	22.7	26.8	34.9	27.8	25	18.6	15.0	35.9	12.3	15.8	36.3	27.8	28	3.8	14.8	13	2.1	3.8	6.2
Total	**32.6**	**18.1**	**28.6**	**34.5**	**17.6**	**25.8**	**20.7**	**17.5**	**39**	**10.7**	**27.2**	**34.5**	**16**	**27.6**	**4.6**	**18.5**	**9.5**	**2**	**3.8**	**6.4**

Table 28: Disposal of children's stools

Percent distribution of youngest children under age 2 living with the mother by the manner of disposal of the child's last faecal matter, and percentage of children whose stools are disposed of safely, according to background characteristics, Uganda DHS 2022

	Manner of disposal of children stool														Percentage of children whose stools are disposed of safely	
	Child used toilet or latrine		Put/rinsed into toilet or latrine		Buried		Put/rinsed into drain or ditch		Thrown into garbage		Left in the open		Other			
	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National	Refugee	National
Mother's education																
No education	3.6	1.6	65.5	51.7	5.4	24.8	17.9	4.5	6.1	15.4	1.5	1	0	1.2	74.5	78.1
Primary	2.3	2.8	72	68.8	3.8	5.9	12.7	12	5.6	6.5	3	1.8	0.4	2.2	78.2	77.5
Secondary	1.3	2.4	69.4	76.3	4.6	3.2	15.8	8.3	1.6	5.6	4.1	1.3	3.1	2.9	75.3	82
Higher	0	3.7	67.7	78.3	0	2.5	32.3	5.6	0	6.8	0	0.5	0	2.5	67.7	84.6
Wealth quintile																
Lowest	4.7	2.7	58.8	55	8.3	19.2	23.4	8.3	2.6	11.7	1.4	1.6	0.7	1.5	71.9	76.9
Second	0	2.7	73.9	70	4.1	4.3	12.2	14.6	6.3	4.6	1.9	1.6	1.6	2.2	78	77
Middle	0.9	3.2	70.3	69.4	2.3	3.6	16.1	12.7	7.1	6.9	3.4	2.3	0	1.8	73.5	76.3
Fourth	1	2.7	74	77.1	4.9	1.5	10.7	8.9	5.2	5.6	4.2	1.2	0	2.9	79.9	81.1
Highest	7.4	2	72.1	80.9	1.1	1.6	10.8	6	6.3	5.4	2.3	1	0	3.2	80.6	84.5
Total	**2.7**	**2.7**	**69.2**	**70**	**4.5**	**6.5**	**15.3**	**10**	**5.3**	**7**	**2.5**	**1.5**	**0.5**	**2.3**	**76.3**	**79.1**

Table 29: Percentage of children (Refugee)under age 5 classified as malnourished according to three anthropometric indices of nutritional status: Height-for-age (stunting), weight-for-height (wasting & over weight), and weight-for-age (underweight), according to background characteristics, Uganda DHS 2022

	Height-for-age (Stunting)				Weight-for-height (Wasting) or (Over Weight)					Weight-for-age (Under-weight)			
Background Characteristics	**Percentage below -2 SD**	**Percentage below -3 SD**	**Mean Z-score (SD)**	**Number of children**	**Percentage below -2 SD**	**Percentage below -3 SD**	**Percentage above +2 SD**	**Mean Z-score (SD)**	**Number of children**	**Percentage below -2 SD**	**Percentage below -3 SD**	**Mean Z-score (SD)**	**Number of children**
Age in Months													
<6	8.7	5.5	0.6	67	8.6	4.1	15.0	0.2	71	10.0	7.2	0.7	69
6-11	12.6	4.8	0.0	60	9.3	2.7	6.7	-0.1	60	5.3	1.3	-0.1	61
12-23	32.3	17.5	-1.3	134	5.5	0.9	2.7	0.1	137	17.8	5.1	-0.6	138
24-35	29.4	14.5	-1.4	150	3.6	0.5	1.9	0.0	150	11.4	5.1	-0.7	151
36-47	32.8	10.9	-1.3	159	2.8	0.0	2.1	0.1	159	10.7	2.0	-0.8	160
48-59	27.1	11.2	-1.3	125	2.4	0.0	1.3	-0.0	122	13.1	5.0	-0.9	125
Sex of Chiold													
Male	29.2	12.7	-1.2	338	6.4	1.6	2.6	-0.2	340	16.4	5.8	-0.8	344
Female	24.6	11.3	-0.9	357	2.9	0.4	4.9	0.2	359	8.1	2.8	-0.3	360
Education of caretaker													
No Education	41.2	19.3	-1.5	207	2.6	0.0	3.8	0.3	210	16.8	6.0	-0.7	212
Primary	21.5	8.9	-0.8	364	5.7	1.8	3.0	-0.1	364	10.3	3.7	-0.5	368
Secondary	15.3	6.1	-0.6	68	3.5	0.0	8.6	0.2	69	7.1	3.2	-0.2	69
Higher	**na***	**na***	**na***	**6**	23.2	**na***	**na***	**na***	**6**	**na***	**na***	**na***	**6**
Wealth Quintile													
Lowest	45.7	22.8	-1.8	148	3.3	1.7	4.3	0.3	152	18.0	7.5	-0.9	153
Second	23.3	12.6	-0.9	116	10.9	1.4	3.1	-0.2	114	15.1	9.5	-0.7	115
Middle	22.6	9.4	-0.7	128	2.5	1.9	2.1	-0.2	127	11.9	2.7	-0.5	128
Fourth	23.2	7.5	-0.8	130	3.7	0.0	5.5	0.0	131	8.5	1.2	-0.4	132
Highest	16.5	5.1	-0.6	123	3.6	0.0	4.0	0.3	125	5.7	0.9	-0.2	127
Uganda	**26.9**	**12.0**	**-1.0**	**645**	**4.6**	**0.9**	**3.8**	**0.0**	**649**	**12.1**	**4.3**	**-0.6**	**655**

Table 30: Percentage of children (Host)under age 5 classified as malnourished according to three anthropometric indices of nutritional status: Height-for-age (stunting), weight-for-height (wasting & over weight), and weight-for-age (underweight), according to background characteristics, Uganda DHS 2022

	Height-for-age (Stunting)				Weight-for-height (Wasting) or (Over Weight)					Weight-for-age (Under-weight)			
Background Characteristics	**Percentage below -2 SD**	**Percentage below -3 SD**	**Mean Z-score (SD)**	**Number of children**	**Percentage below -2 SD**	**Percentage below -3 SD**	**Percentage above +2 SD**	**Mean Z-score (SD)**	**Number of children**	**Percentage below -2 SD**	**Percentage below -3 SD**	**Mean Z-score (SD)**	**Number of children**
Age in Months													
<6	20.3	4.9	-0.2	47	2.8	1.4	3.3	0.3	54	11.4	3.3	0.1	48
6-11	12.3	4.2	-0.4	48	1.6	0.0	1.6	-0.1	51	9.0	3.1	-0.4	51
12-23	35.3	14.5	-1.4	95	6.5	2.4	7.7	0.2	96	9.1	3.9	-0.6	96
24-35	33.0	16.3	-1.5	94	0.8	0.0	3.0	0.2	95	12.2	0.8	-0.7	95
36-47	35.4	10.0	-1.3	99	0.0	0.0	2.3	0.1	98	11.2	0.8	-0.7	98
48-59	30.1	9.4	-1.3	102	3.2	2.4	2.6	-0.0	99	8.4	0.8	-0.8	101
Sex of Child													
Male	38.1	13.0	-1.4	227	2.0	1.7	4.7	0.1	231	12.3	2.4	-0.7	229
Female	23.0	9.0	-0.9	258	3.0	0.6	2.6	0.1	262	8.3	1.5	-0.5	260
Education of caretaker													
No Education	38.9	17.4	-1.6	51	2.8	1.3	1.9	0.1	54	11.4	0.0	-0.9	51
Primary	30.3	10.1	-1.1	345	2.0	1.3	4.2	0.1	350	11.3	2.2	-0.6	350
Secondary	23.8	11.0	-1.0	74	4.4	0.0	1.4	-0.0	74	4.9	2.1	-0.6	74
Higher	**na***	**na***	**na***	**15**	**na***	**na***	**na***	**na***	**15**	**na***	**na***	**na***	**14**
Wealth Quintile													
Lowest	26.1	8.8	-1.1	107	4.3	3.6	2.4	0.0	109	10.6	4.4	-0.6	108
Second	28.4	11.5	-1.0	96	2.3	1.5	1.3	0.1	98	10.1	1.6	-0.5	96
Middle	42.1	19.1	-1.5	93	2.9	0.0	5.1	0.1	96	12.7	0.8	-0.8	95
Fourth	29.3	6.7	-1.2	93	1.3	0.0	3.3	0.2	94	8.5	0.8	-0.5	94
Highest	25.1	8.8	-1.0	96	1.5	0.0	6.1	0.1	96	9.0	1.5	-0.5	96
Uganda	**30.1**	**10.9**	**-1.2**	**485**	**2.5**	**1.1**	**3.6**	**0.1**	**493**	**10.2**	**1.9**	**-0.6**	**489**

UGANDA BUREAU OF STATISTICS

Statistics House, Plot 9, Colville Street

P.O Box 7186, Kampala-Uganda

Tel: +256 414-706000

Email: ubos@ubos.org

website: www.ubos.org

Uganda Bureau of statistics @statisticsug